National Rural Health Association

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1809-P; Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure.

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Hospital Outpatient Prospective Payment System for calendar year (CY) 2025. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

II. Proposed Updates Affecting OPPS Payments.

B. Proposed Conversion Factor Update.

NRHA thanks CMS for its 2.6% payment update relative to CY 2024. **We are pleased to see that rural hospitals across the board will have a slightly higher payment update at 2.8%. However, NRHA continues to be concerned about the discrepancy between Medicare payment rates and actual inflation.** For July 2024, the Consumer Price Index for hospital services was 6.1% meaning that Medicare reimbursement will continue to fall behind the actual cost of providing care to beneficiaries.[1] Compounding CMS' underpayment, rural hospitals and health systems also face labor and supply cost pressures and workforce shortages. The projections that CMS uses for updating

[1] Press Release, Bureau of Labor Statistics, Department of Labor, Consumer Price Index – July 2024 (Aug. 14, 2024), https://www.bls.gov/news.release/pdf/cpi.pdf.

payment rates have recently been lower than actual inflation because historical data is used. Using historical inflation data leads to inadequate payment updates.

It is critical that CMS explores how it can accurately pay rural hospitals by accounting for inflation and historical underpayment. Nearly 180 rural hospitals have closed or ceased inpatient services since 2010, the majority of which were PPS hospitals.[2] Estimates show that an additional 418 rural hospitals are vulnerable to closure.[3]

Closures are only one measure of hospital financial instability. Half of rural hospitals are operating in the red.[4] The median operating margin for independent rural hospitals is -2.2% and the median for system-affiliated rural hospitals is 1.7%.[5] When hospitals are operating with low or negative margins they often cut less profitable yet important service lines, most notably obstetrics or chemotherapy, leaving rural beneficiaries without a local point of access to care. **We urge CMS to finalize higher payment rates for CY 2025 to help sustain access to care for Medicare beneficiaries in rural communities.**

NRHA supports CMS' proposed continuation of the 7.1% payment adjustment for rural sole community hospitals (SCHs). We ask CMS to finalize this policy as proposed. We also ask that CMS consider extending this payment increase to Medicare Dependent Hospitals (MDHs), which by definition are rural hospitals. **CMS has the authority to make this change without legislation through a study of costs incurred by rural hospitals compared to urban hospitals.** CMS should perform another study to look at the costs that MDHs incur and make an adjustment similar to what SCHs receive to help support the rural health safety net.

VII. Proposed OPPS Payment for Hospital Outpatient Visits

In the CY 2023 OPPS final rule, CMS finalized a policy to exempt rural SCHs from its policy to pay for hospital outpatient clinic visits furnished at off-campus provider-based departments at the Medicare Physician Fee Schedule (MPFS) rate, or 40% of the OPPS rate. CMS proposes to continue this exemption and NRHA supports this proposal.

NRHA urges CMS to consider exempting small rural hospitals with less than 100 beds, MDHs, and Low-Volume Hospitals in a future rulemaking cycle. The same reasoning that led CMS to

[2] Rural Hospital Closures, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill https://www.shepscenter.unc.edu/programsprojects/rural-health/rural-hospital-closures/; Rural Emergency Hospitals, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals/ (this number includes hospitals that converted to another hospital type, such as the Rural Emergency Hospital designation).

[3] Michael Topchik, et al., *Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory*, Chartis Center for Rural Health (2024), 7 https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf.

[4] *Id.*

[5] *Id.* at 2-3.

propose to exempt SCHs also applies to all small rural hospitals. Factors other than the payment differential can be attributed to the volume of services in provider-based clinics of rural hospitals.

Since 2010, 28 MDHs have closed their doors. GAO likewise found that Medicare profit margins and total hospital profit margins declined for MDHs from fiscal year 2011 through 2017, from -6.9% to -12.9% and 1.6% to -0.2%, respectively.[6] The degree to which Medicare margins declined for MDHs during this time period (6%) was greater than the degree to which they declined for rural hospitals (3.8%) and all hospitals (2.5%).[7] Extending this site neutral exemption to MDHs would ensure rural hospitals receive more adequate reimbursement and thus support access to care for beneficiaries in rural areas. **CMS must finalize its proposal to continue to exempt rural SCHs and extend the same relief to MDHs.**

VIII. Payment for Partial Hospitalization and Intensive Outpatient Services.

NRHA appreciates CMS' proposed payment updates for IOP services as well as its related proposal in the CY 2025 Medicare Physician Fee Schedule to make rural health clinics (RHCs) and FQHCs eligible to bill for 4-service days.

NRHA has limited information on how many rural providers have added IOP services since Medicare began paying for them in 2024. NRHA members have generally agreed that the 3- and 4-service day rates were not enough during CY 2024 to furnish these services, especially for RHCs. One grandfathered provider-based RHC in Texas noted that the payment for IOP services in CY 2024 was only slightly higher than its all-inclusive rate (AIR), therefore it made more sense to provide two AIR visits in one hour instead of providing IOP services. Also, because IOP rates are based on OPPS rates the payment is not adequate for RHCs associated with a critical access hospital (CAH). Billing for IOP services at the 3-service rate is likely more beneficial for new RHCs that are not grandfathered into the old payment methodology. Other NRHA members have generally signaled interest in IOP services but agreed that payment and recruiting staff are barriers. With the payment rate update, NRHA is hopeful that more RHCs and rural hospitals will begin furnishing these services.

X. Nonrecurring Policy Changes.

B. Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) Services and Diagnostic Services Furnished to Hospital Outpatients.

CMS proposes to continue its flexibility to allow the availability for virtual direct supervision of CR, ICR, and PR services through December 31, 2025. **NRHA appreciates this extension and urges CMS to make virtual direct supervision for these services permeant.** A continuation of this policy is key for providers because they need time to reorganize and readjust policies to meet pre-Public Health Emergency (PHE) rules again.

[6] Government Accountability Office, *Information on Medicare-Dependent Hospitals*, (Feb. 2020), 21 https://www.gao.gov/assets/gao-20-300.pdf.
[7] *Id.*

C. All-Inclusive Rate (AIR) Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities.

NRHA supports CMS' proposal to pay Indian Health Service (IHS) and tribal hospitals separately for high-cost outpatient drugs. We agree with CMS' conclusion that paying separately for these drugs will enable IHS and tribal hospitals to continue to or begin to provide much-needed specialty care.

XVIII. Medicaid Clinic Services Four Walls Exceptions.

B. Provisions of the Proposed Regulations.

States may offer Medicaid clinic services as an optional benefit category. One requirement for this benefit is that Medicaid clinic services be furnished onsite. This is referred to as the "four walls" requirement. CMS proposes to expand the exceptions to the four walls requirement to clinics in rural areas, IHS and tribal clinics, and behavioral health clinics. **NRHA supports these proposed exceptions as they will foster access to care for rural and tribal communities.**

CMS is soliciting comments on how to define rural for the purposes of exempting clinics from the four walls requirement. CMS is considering whether to apply a federal definition, allow states to adopt a state or federal definition, or to not define rural at all. **NRHA suggests that CMS allow states to choose a state *or* federal definition of rural in order to meet their unique geographic needs.** Oftentimes when CMS applies a broad definition, like Metropolitan Statistical Area (MSA) or non-MSA to policies, certain rural communities are improperly grouped with urban areas. Giving states the ability to choose a state or federal definition that best represents their rural communities will ensure that clinics that would most benefit from the exception are eligible. Alternatively, CMS could use the Federal Office of Rural Health Policy definition[8] of rural to establish exemption criteria.

XIX. Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process.

NRHA applauds CMS for shortening the prior authorization timeline for Medicare fee-for-service (FFS) outpatient requests to 7 calendar days. We appreciate that CMS is aligning the timeline for standard outpatient department requests with that of other payers. This proposal will create equity for all patients waiting to access care and may help reduce provider burden by streamlining processes across all payers.

XX. Provisions Related to Medicaid and the Children's Health Insurance Program (CHIP).

A. Continuous Eligibility in Medicaid and CHIP (42 CFR 435.926 and 457.342).

NRHA commends CMS for its work to ensure children remain covered by Medicaid and CHIP. Medicaid is an important source of coverage for rural residents and a key payer for rural hospitals.

[8] *See* Health Resources and Services Administration, *Defining Rural Population*, last updated January 2024, https://www.hrsa.gov/rural-health/about-us/what-is-rural.

Importantly, **Medicaid and CHIP cover almost half of all rural children.**[9] Rural residents are more likely to be low-income and unemployed[10] and for individuals that are employed, rural employers are less likely to provide insurance.[11] Thus Medicaid fills in gaps in coverage and access in rural America. As such, **we strongly support CMS' proposal to make continuous eligibility for children enrolled in Medicaid and CHIP a requirement for state Medicaid plans.**

XXI. Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals.

NRHA commends CMS for its continued focus on ending rural maternal health disparities. **Between 2011 and 2021, 267 rural hospitals ceased providing obstetrical (OB) care, representing 25% of rural America's OB units.**[12] These closures are threatening access to care and contributing to the rural maternal health crisis. Unfortunately, as rural hospitals face difficult financial situations, closing service lines is an intermediary step before closing the hospital. Given the low volume of births in rural areas, coupled with financial challenges and workforce shortages generally experienced by rural hospitals, OB units are one of the first service lines to be ended.

To help address maternal health outcomes nationwide, CMS proposes new OB services conditions of participation (COPs) and amendments to emergency services and Quality Assessment and Performance Improvement (QAPI) COPs. NRHA appreciates CMS' goal of improving maternal health outcomes; however, we are concerned that potential unfunded mandates placed on vulnerable rural providers may further threaten rural access to care.

B. Provisions of the Proposed Regulations.

NRHA urges CMS to exempt rural hospitals and CAHs from the proposed COPs. Again, NRHA agrees with and supports CMS' mission to address and improve maternal health outcomes**. However, we are extremely concerned with the current trend of OB unit closures and the impact that complying with new COPs will have on the remaining OB units in rural hospitals. We maintain that imposing one-size-fits-all COPs on rural hospitals and CAHs will lead to more OB unit closures.** Research suggests that lack of access to hospital-based OB care worsens outcomes and lowers the likelihood of adequate prenatal care.[13] Imposing COPs on vulnerable rural hospitals and

[9] Aubrianna Osorio, Joan Alker, & Edwin Park, *Medicaid's Coverage Role in Small Towns and Rural America*, GEORGETOWN CENTER FOR CHILDREN AND FAMILIES, GEORGETOWN UNIVERSITY MCCOURT SCHOOL OF PUBLIC POLICY, Aug. 17, 2023, https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas/.

[10] Julia Foutz, Samantha Artiga, & Rachel Garfield, *The Role of Medicaid in Rural America*, KAISER FAMILY FOUNDATION, Apr. 25, 2017, https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/.

[11] CENTER FOR BUDGET AND POLICY PRIORITIES, *Medicaid Works for People in Rural Communities* (Jan. 19, 2018) https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities.

[12] Topchik, et al., *Rural America's OB Deserts Widen in Fallout From Pandemic*, Chartis (2024), 1, https://www.chartis.com/sites/default/files/documents/rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf.

[13] Stephanie M. Radke, et al., *Closure of Labor & Delivery units in rural counties is associated with reduced adequacy of prenatal care, even when prenatal care remains available*, 39 J. RURAL HEALTH 746, 750 (2023) https://onlinelibrary.wiley.com/doi/epdf/10.1111/jrh.12758.

CAHs will ultimately cut against CMS' goal of improving maternal health outcomes. Rural hospitals disproportionately rely upon Medicare and Medicaid reimbursement as they make up the majority of their patient population. **The magnitude of the effect of not complying will have a chilling effect on rural hospitals such that they will preemptively cease providing OB care to preserve their participation in Medicare and Medicaid.**

1. Organization, Staffing, and Delivery of Services (§ 482.59 and § 485.649).

CMS proposes COPs related to the organization, staffing, and delivery of services in an OB unit. Many of the proposals may already be happening in rural hospitals; however, it is not appropriate to mandate these practices beyond existing accrediting practices. We appreciate the flexibility given in certain areas such as not prescribing who or how hospitals train staff on OB care and allowing flexibility around which evidence-based guidelines to use for developing protocols around OB emergencies. **NRHA disagrees that COPs are the answer to improving maternal health in rural areas and urge CMS to relieve rural hospitals and CAHs of these requirements.**

Regarding CMS' proposal for staffing, we are concerned about CMS' definition of an "experienced" clinician to supervise L&D rooms and suite and post-partum rooms at all times. Small rural hospitals and CAHs may have a low volume of labor and delivery services and therefore may not be able to maintain a staff cohort of veteran obstetrical staff 24/7. CMS should allow for flexibility around staffing requirements and allow small rural hospitals and CAHs to have "experienced" staff available on call-on for when obstetric emergencies take place to provide guidance to onsite RN, CNM, NP, PA, or physicians.

Additionally, we are concerned around requirements for equipment at proposed § 482.59(b) § 485.649(b). CMS proposes that hospitals and CAHs have a call-in-system, cardiac monitor, and fetal doppler or monitor available to labor and delivery room suites. We ask that CMS clarify its definition of "available." Many rural hospitals and CAHs likely have this equipment available to the unit but not in every labor and delivery room. CMS should allow flexibility around equipment requirements and allow hospitals to have this equipment available in relation to patient needs. For example, if a CAH typically has one patient in its OB unit at any given time, one set of equipment for the unit should be sufficient to meet this requirement.

One way that CMS can help improve maternal health outcomes is to assist rural hospitals with OB readiness. NRHA asks that CMS consider providing resources, such as technical assistance, to help rural hospitals achieve this goal. A broad emergency services readiness COP, described below in Section 3, is redundant and will not further readiness for OB emergencies. For example, S. 4079/H.R. 8383, the Rural Obstetric Readiness Act[14] would help prepare rural hospitals and providers to handle the obstetric emergencies that come into their emergency rooms. This would be achieved through supporting facilities with the purchase of necessary equipment and developing a workforce that is able to respond, creating a pilot program to support statewide or reginal networks of obstetric care teams to provide tele-consultation, and creating an obstetric emergency training program for rural facilities that do not have a labor and delivery unit. While this program would be housed in the Health

[14] Rural Obstetrics Readiness Act, S. 4079, 118th Cong. (2024) https://www.congress.gov/bill/118th-congress/senate-bill/4079.

Resources and Services Administration, it can serve as a model for the kind of technical assistance that CMS could help provide.

3. Quality Assessment and Performance Improvement (QAPI) Program (§ 482.21; § 485.641).

CMS proposes that hospitals and CAHs that offer OB services be required to use their QAPI programs to assess and improve outcomes and disparities among OB patients. **We urge CMS to exclude rural hospitals and CAHs from this proposal.** If CMS moves forward with finalizing this proposal, we ask that CMS provides flexibility around the requirement to incorporate Maternal Mortality Review Committee (MMRC) data and recommendations into hospitals' QAPI programs. Almost every state has a statewide MMRC meaning that their state data or recommendations may be more urban-centric and not relevant to or representative of rural hospitals. CMS should allow hospitals to instead use data and recommendations from any organization that is working on OB quality in their area.

4. Emergency Services Readiness (§ 482.55; § 485.618).

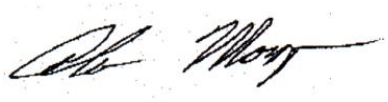
NRHA urges CMS against finalizing this addition to emergency services COPs. The new provisions under § 482.55 and § 485.618 would apply to all emergency services. **These provisions are redundant as hospitals and CAHs must meet existing emergency services COPs and comply with EMTALA,** both of which aim to achieve the same patient safety goals as the proposed COPs**.** Adding an additional set of emergency services COPs on rural hospitals and CAHs will be a financial, administrative, and staff burden that these providers cannot shoulder and serve as an unfunded mandated to already struggling rural facilities.

The proposed provisions are duplicative for CAHs in particular and must not be finalized. CAHs are already meeting a similar, if not almost identical, standard at § 485.618(b)-(c) to those proposed. Additionally, CMS proposes to add that CAHs must have a physician immediately available by phone on a 24/7 basis to receive emergency calls, provide information on treatment, and refer patients to the CAH or another location. Yet CAHs must currently comply with a similar requirement in § 485.618(d) which requires that a practitioner be on call or immediately available by phone and available onsite within 30 minutes on a 24-hour basis.[15] CMS' proposal would require that a physician, rather than a non-physician practitioner, be available by phone 24/7, which is more difficult to meet in the face of the workforce shortages that CAHs experience. **We assert that CAHs are presently meeting an extremely similar standard regarding emergency services and the existing standard was designed with rural workforce limitations in mind.** Therefore, new one-size-fits-all standards are not appropriate and will result in additional untenable burdens for CAHs.

Thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work together towards our mutual goal of improving health care and access for rural Americans. If you have any questions or would like to discuss further, please contact NRHA's Government Affairs and Policy Director Alexa McKinley Abel at amckinley@ruralhealth.us.

Sincerely,

[15] In frontier areas, the practitioner must be available within 60 minutes.



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