July 6, 2020

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Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1735-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals.

Dear Administrator Verma:

On behalf of the Rural Hospital Coalition, please accept these comments on the Hospital Inpatient Prospective Payment System ("IPPS") proposed rule.

The Rural Hospital 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. The Coalition shares the common goal of ensuring that federal hospital payment 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 pleased to provide the Centers for Medicare and Medicaid Services ("CMS") with these comments.

Rural Hospital Designations: Overview

Medicare Dependent Hospitals: The MDH program was established by Congress in 1990 with the intent of supporting small rural hospitals for which Medicare patients make up a significant percentage of inpatient days and discharges. Because they primarily serve Medicare beneficiaries, MDHs rely heavily on Medicare reimbursement to sustain hospital operations. Consequently, these hospitals are more vulnerable to inadequate Medicare payments than other hospitals because they are less able to cross-subsidize inadequate Medicare payments with more generous payments from private payers. As such, Congress acknowledged the importance of Medicare reimbursement to MDHs and established special payment protections to buttress these hospitals. Congress recognized that if these hospitals were not financially viable and failed, Medicare beneficiaries would lose an important point of access to hospital services. Many of these hospitals also have substantial Medicaid patient populations.

Sole Community Hospitals: Congress created the SCH program nearly 40 years ago to maintain access to needed health care services for Medicare beneficiaries in isolated communities. Congress was concerned that as it moved Medicare to fixed, per-service payments under the IPPS, hospitals whose costs exceeded IPPS payments could be financially threatened, and that the Medicare program and its beneficiaries would suffer if hospitals serving isolated, rural populations failed because of this financial shortfall. The SCH program is intended to maintain the viability of hospitals providing critical health care services to their communities.

Rural Referral Centers: Congress established the RRC program to support rural hospitals that treat a large number of complicated cases and function as regional referral centers. Generally, to be classified as an RRC, a hospital has to be physically located outside a Metropolitan Statistical Area (indicating an urban area) and either have at least 275 beds or meet certain case-mix or discharge criteria.

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 and 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.

Impact of MS-DRG and Relative Weight Changes and Corresponding Budget Neutrality Adjustments

The Coalition wishes to once again call to CMS's attention a disturbing and ongoing trend that is further challenging rural hospitals, and especially MDHs, RRCs and SCHs. According to the Table I, the Impact

Analysis of Proposed Changes (85 *Fed. Reg.* 32,934-36), rural hospitals are systematically and disproportionately disadvantaged by annual MS-DRG changes, including changes to the relative weights that occur as part of recalibration, and the budget neutrality adjustment CMS applies to ensure that these changes do not increase payments from year-to-year. As you can see from the table below, rural hospitals generally, and hospitals designated as RRCs, SCHs and MDHs in particular are distinctly and disproportionately negatively impacted by these annual changes and recalibration.

Weights and DRG Changes with Application of Recalibration Budget Neutrality Values Comparison Between Urban and Rural Hospitals From 2014 to 2021[1]

Fiscal Year	Urban	Rural	RRC	SCH	MDH	SCH and RRC	MDH and RRC	Data source
2014	0	-0.4	-0.1	-0.6	-0.7	-0.3	-0.5	IPPS FY 2014 Final Rule
2015	0	-0.2	0	-0.2	-0.3	-0.3	-0.3	IPPS FY 2015 Final Rule Correction
2016	0	-0.2	-0.1	-0.3	-0.3	-0.3	-0.3	IPPS FY 2016 Final Rule Correction
2017	0	-0.4	-0.1	-0.3	-0.6	-0.3	-0.6	IPPS FY 2017 Final Rule Correction
2018	0	0.1	0.1	-0.2		-0.1		IPPS FY 2018 Final Rule Correction
2019	0	-0.3	0	-0.5	-0.5	-0.2	-0.4	IPPS FY 2019 Final Rule
2020	0	-0.3	0	-0.3	-0.4	-0.3	-0.5	IPPS FY 2020 Final Rule Correction
2021	0	0	0.1	-0.2	-0.4	-0.2	-0.3	IPPS FY 2021 Proposed Rule
Total	**0**	**-1.7**	**-0.1**	**-2.6**	**-3.2**	**-2**	**-2.9**	

This particular column in Table I estimates the impact of MS-DRG changes, recalibration and a budget neutrality adjustment that is necessary to offset any payment increases that result from these changes year-to-year. The budget neutrality adjustment is relatively small and is applied uniformly to the standardized amount and the hospital-specific payment rate. The effects of MS-DRG changes and recalibration, however, are not uniform. An impact of greater than zero percent in this column for a hospital subgroup indicates that MS-DRG changes and recalibration more than offset the budget neutrality adjustment for these hospitals and result in a net increase for the subgroup. An impact of less than zero percent indicates that MS-DRG changes and recalibration are insufficient to offset the budget neutrality adjustment and result in a net decrease for the subgroup. For some subgroups that are particularly negatively affected, the net decrease is greater than the uniformly applied budget neutrality factor suggesting that MS-DRG changes and recalibration contribute to additional losses. As the table indicates these annual MS-DRG changes, recalibration and the budget neutrality adjustment benefit certain hospitals while harming others, and they especially harm hospitals designated as RRCs, SCHs and MDHs.

As such, we urge CMS to examine how the current ratesetting methodology contributes to this phenomenon and consider making an adjustment, if deemed appropriate. CMS has committed

[1]Inpatient Prospective Payment System Rules, Table 1 Impact Analysis (FY 2014 to 2021).

itself to supporting rural hospitals. This is an instance where CMS policy is doing the opposite, widening the gap between urban and rural hospitals and undermining the viability of rural hospitals. CMS has ample authority to make such an adjustment under section 1886(d)(5)(I)(i) of the Social Security Act, which the Secretary has interpreted as authorizing "other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." CMS also has precedent for making such adjustments (CMS adjusted payments when it implemented the MS-DRGs relying in part on this authority).

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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