June 7, 2022

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Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–1771–P
7500 Security Boulevard
Baltimore, MD 21244

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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

Dear Administrator Brooks-LaSure:

On behalf of the Alliance for Rural Hospital Access (ARHA, or the Alliance), please accept these comments on the Hospital Inpatient Prospective Payment System (IPPS) proposed rule.

The Alliance 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 Alliance 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, ARHA 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.

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.

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.

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 Alliance has consistently commented on the impact of annual Medicare Severity Diagnosis Related Group (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—on rural hospitals.

In recent years, there has been an ongoing, concerning trend in which rural hospitals are systematically and disproportionately disadvantaged by annual MS-DRG changes. As set forth in the following table, rural hospitals have been markedly impacted by these annual changes and recalibrations in a negative manner:

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**	

Over the past two years—for the first time in some time—the trend of rural hospitals being disproportionately, negatively impacted by these adjustments appears to be moderating. CMS' impact table in the current FY 2023 proposed rule shows the following impacts resulting from the MS-DRG changes (with similar impacts in last year's final FY 2022 IPPS rule):

Hospital Type	**Proposed FY 2023 Weights and DRG Changes with Application of Budget Neutrality**
All Urban	0.0
All Rural	0.1
RRC	0.0
SCH	0.0
RRC and SCH	0.1

ARHA and its member hospitals were pleased to see these impacts in FY 2022 and FY 2023, but we are not aware of any specific steps CMS took to fix this longstanding issue. Instead, it appears as though the last two years have simply been less disadvantageous for rural hospitals, and the Alliance remains concerned that the systemic methodologies CMS uses to make these adjustments could cause adverse impacts again in the future.

While the slowing of this trend does come as a relief, the Alliance remains concerned about the long-term sustainability and viability of its member hospitals—and *all* rural hospitals—and their ability to serve vulnerable communities. **For this reason, ARHA believes it is still essential that CMS examine how its current rate-setting methodology can contribute to disproportionate disadvantages to rural hospitals. Additionally, should this examination**

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

reveal such systematic, negative impacts on rural hospitals, CMS should consider making payment methodology adjustments.

CMS has committed itself to supporting rural hospitals. This is an instance where CMS policy has done the opposite in recent years, 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).

Extension of MDH and Low-Volume Adjustment

As noted above, the MDH designation was created by Congress more than 30 years ago to buttress hospitals dependent upon Medicare reimbursement and thus 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. The program has been reauthorized 10 times, most recently in 2018, but is due to expire again on October 1, 2022, unless Congress intervenes.

The low-volume Medicare adjustment was created in 2005 and helps to level the playing field for hospitals in small, isolated communities whose operating costs often outpace their revenue. The low-volume adjustment has been reauthorized seven times, most recently in 2018, and—like the MDH program—is due to expire on October 1, 2022, without congressional action.

The Alliance is working with key Senators and Representatives to advance legislation that would extend the MDH program and the low-volume adjustment (S. 4009/H.R. 1887). While Congress has extended these programs numerous times with bipartisan support, the current expiration looming at the conclusion of FY 2022 is concerning, as the proposed FY 2023 IPPS rule assumes such an expiration.

The loss of the MDH and low-volume programs would have severe, adverse impacts on these vulnerable rural hospitals and the communities they serve. Over the years, these hospitals have continually operated under a near-constant uncertainty about the future of this revenue support. Such uncertainty has discouraged hospitals from making the types of capital and infrastructure investments necessary to expand services, modernize facilities, and focus on other improvements to patient care.

Most recently, as hospitals plan their FY 2023 budgets, they are not able to assume that these critical programs will be extended, and therefore are taking steps to account for this lost revenue and alleviate its impact. Such adjustments and cutbacks are especially detrimental to rural communities as the COVID-19 public health emergency (PHE) continues—at a time the rural health care safety net needs to be shored up, not weakened.

The Alliance urges CMS to expedite restoration of MDH status and the low-volume adjustment, should Congress again act to extend these programs. Past retroactive restorations have seen delays that caused significant cash flow problems to affected hospitals. In the event that Congress again acts to extend these programs, but does not do so until after the October 1, 2022, expiration date, we ask CMS to move expeditiously to restore payments, in order to ensure these rural facilities remain viable and are able to continue to provide quality care to their communities.

The Alliance recognizes CMS regards these programs as ending on September 30, and that the agency typically does not create policy around actions Congress may take in the future. Nonetheless, the loss of these important payment protections to a hospital and the community it serves can be profound. CMS could go a long way toward minimizing disruptions to beneficiary access to hospital care by clarifying how it might handle program extensions, should Congress enact legislation to extend them.

Current PHE Waivers and Future Post-PHE Transition

Under the current COVID-19 PHE, CMS has waived certain eligibility requirements for MDHs and SCHs classified as such prior to the PHE. For SCHs CMS waived the distance requirements at paragraphs (a), (a)(1), (a)(2), and (a)(3) of 42 CFR § 412.92 and the "market share" and bed requirements (as applicable) at 42 CFR § 412.92(a)(1)(i) and (ii). For MDHs, CMS waived requirements at 42 CFR § 412.108(a)(1)(ii) that the hospital has 100 or fewer beds during the cost reporting period, and the eligibility requirement at 42 CFR § 412.108(a)(1)(iv)(C) that at least 60 percent of the hospital's inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits during the specified hospital cost reporting periods.

CMS waived these requirements for the duration of the PHE to allow these hospitals to meet the needs of the communities they serve during the PHE, such as to provide for increased capacity and promote appropriate cohorting of COVID-19 patients. These waivers are intended to expire at the conclusion of the PHE and, while this future, post-PHE expiration is reasonable, the Alliance is concerned that an immediate return to pre-pandemic requirements after the PHE's expiration may jeopardize the ability of MDHs and SCHs to meet market and/or patient share requirements as service delivery and care patterns normalize.

As such, ARHA urges CMS to consider extending these waivers through the end of the cost reporting year in which the PHE ends. Allowing for reasonable transitions such as this will ensure that rural hospitals are able to continue to meet the needs of their communities as the nation shifts away from the PHE, thus minimizing any transitional impacts on vulnerable patient populations.

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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