December 13, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1695-P
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Listening Session on Rural Health Care Transformation (December 10, 2018) – Follow-up Comments and Suggestions**

Dear Administrator Verma:

On behalf of the Rural Hospital Coalition (the Coalition), thank you for the invitation to participate in the listening session on rural health care transformation, held on December 10, 2018. The Coalition applauds your interest in and concern for these issues, and greatly appreciates the opportunity to contribute to this important discussion.

The Coalition represents nearly 100 hospitals nationwide with Rural Referral Center (RRC), Sole Community Hospital (SCH) or Medicare Dependent Hospital (MDH) status under the Medicare program, and is delighted to provide perspectives from these important institutions. We agree with the five objectives CMS set forth in the Rural Health Strategy CMS released earlier this year—particularly the need to apply a rural lens to CMS programs and policies. **While we support CMS' broad commitment to transformation, we believe that an essential precursor to transformation in rural areas is stabilization of the institutions that serve those communities.** Ensuring a strong rural health care safety net is absolutely crucial to protecting rural America's ability to access high-quality health care, and the comments and suggestions we set forth during the listening session—and that are further detailed in this letter—focus on that need for stabilization.

## The Role of RRCs, SCHs and MDHs in the Rural Health Care Infrastructure

RRCs, SCHs and MDHs each play a unique but equally vital role in the rural health care system:

- The RRC program was established by Congress 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, medical staffing and discharge criteria intended to demonstrate that the hospital is providing sophisticated services in a rural area.

- The SCH program was created to maintain access to needed health services for Medicare beneficiaries in isolated communities. The SCH program ensures the viability of hospitals that are geographically isolated and thus play a critical role in maintaining access to care in remote communities. Hospitals qualify for SCH status by demonstrating that because of distance or geographic boundaries between hospitals they are the sole source of hospital services available in a wide geographic area. There are a variety of ways in which hospitals can qualify for SCH status, but the majority qualify by being more than 35 miles from another provider.

- The MDH program was established by Congress to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, and which therefore are vital to providing hospital services to program beneficiaries, and also particularly susceptible to changes in Medicare program policy. To qualify as a MDH, a hospital must be: (1) located in a rural area, (2) have no more than 100 beds, and (3) demonstrate that Medicare patients constitute at least 60 percent of its inpatient days or discharges. Because they primarily serve Medicare beneficiaries, MDHs rely heavily on Medicare payment to sustain hospital operations. As such, Congress acknowledged the importance of Medicare reimbursement to MDHs and established special payment provisions 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.

RRCs, SCHs and MDHs provide rural populations with local access to a wide range of health care services. In addition, many are the sole source of care within and around a rural community. Many patients that live in rural communities depend on these facilities for a full complement of health care services, from primary care to inpatient sophisticated treatment. The closures of rural hospitals remains an on-going trend, causing access problems for residents of rural communities. When an RRC, SCH or MDH closes, the consequences for the community may be more grave than otherwise.

Given the crucial role that RRCs, SCHs and MDHs play in the rural health safety net, the Coalition respectfully requests that CMS consider policies that will buttress and stabilize these rural hospitals. **Our policy recommendations are focused on three key themes:**

- **The need for predictability,**
- **The importance of data-driven policy, and**
- **The need to avoid "artificial" distinctions between rural facilities.**

**Providing Predictability**

Rural hospitals need predictability in order to properly budget their resources. When policy and payment extensions are hanging in the balance every year or two, it is difficult for these hospitals to confidently budget. Even when programs are ultimately extended, without the predictability hospitals, cannot use these extended resources to the maximum benefit.

Ensuring predictability will allow for rural hospitals to maximize the important relief they are given. By making permanent certain rural exceptions and policies, CMS could easily take steps toward providing this predictability.

One example is the rural SCH exception to recent 340B payment cuts under the Outpatient Prospective Payment System (OPPS). The Coalition appreciates that CMS very thoughtfully excepted rural SCHs from the Medicare OPPS 340B payment cuts, but remains concerned that it did so only on an annual basis. In the final OPPS rules for both CYs 2018 and 2019, despite requests from stakeholders for the agency to be more clear and enduring in its commitment, CMS stated: "We may revisit our policy regarding exceptions to the 340B drug payment reduction in the CY 2020 OPPS/ASC rulemaking."

As we stated in our comment letter on the CY 2019 OPPS rule, CMS has recognized that SCHs play a vital role in the rural health care infrastructure. By definition, these hospitals are the sole source of hospital services for a large area (they are either many miles away, separated by geographic barriers, or a minimum driving distance). If an SCH fails, a community is left without access to inpatient hospital services, and residents must travel great distances to access this care. CMS highlighted these challenges in the May 8, 2018, release of its "Rural Health Strategy," where issues such as the unique economies of providing health care in rural America were highlighted.[1]

The uncertainty provided under the current policy – *i.e.,* not knowing if CMS will extend the policy – inhibits investment in services in rural communities, and further strains the rural health care safety net. While this protection helps rural SCHs, the uncertainty surrounding it – *i.e.,* not knowing if or when CMS may revoke the projection – means many rural SCHs are not investing further in community outreach services that may be enabled by 340B program discounts. <u>As such, the Coalition continues to urge CMS to make permanent the rural SCH exception to the 340B payment reductions</u>.

Another example regarding the need for predictability is the 7.1% OPPS payment adjustment for rural SCHs. Under current CMS policy, Medicare payments to rural SCHs for outpatient services are increased by 7.1 percent. CMS makes this adjustment because it found, pursuant to a study required by Congress,[2] that, compared to urban hospitals, rural SCHs have substantially higher costs, and need a payment adjustment to be comparably treated under the outpatient PPS. While CMS has consistently renewed and extended this additional payment, it consistently signals that the policy will be revisited next year. That uncertainty from year-to-year renders

[1] Rural Health Strategy. Rural Health Council. Centers for Medicare & Medicaid Services. May 8, 2018. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf
[2] § 411(b), Pub. L. No. 108-173.

many hospitals unable to take full advantage of the additional revenues because they cannot count on the adjustment being available in the year ahead. When hospitals budget annual spending and investments, some will not build into their budgets revenues that are uncertain. In those instances, the additional revenues are a windfall at year-end. The additional revenues may help close negative margins, but the monies cannot be invested in new services or capacities for the communities these hospitals serve, because they cannot be counted on from year-to-year. CMS could ensure that the recipients of these additional reimbursements are able to put those additional monies to maximum use and benefit by removing some of that uncertainty. The Coalition urges CMS to make permanent the 7.1 percent payment adjustment for rural SCHs.

Finally, while we recognize that it is a statutory program, the Coalition also supports making the MDH designation permanent. Because MDHs serve a disproportionate number of Medicare beneficiaries, MDHs rely on Medicare payments for delivering patient care to these beneficiaries and their broader communities. MDH status and the associated payment protections are critical to the continued viability of these facilities. The Bipartisan Budget Act of 2018 extended the MDH program for five years. While the Coalition appreciates this extension, providing short-term extensions is not a long-term solution. We encourage CMS to explore its authority to create and maintain an MDH-like program that would obviate the need for and uncertainty around the statutory program.

**The Importance of Data-Driven Policy**

For rural policy, the Coalition believes it is essential for CMS to study and understand the consequences of any proposed changes before taking actions that may have negative consequences for rural hospitals. To this end, the Coalition urges CMS to reconsider rural exemptions to the recent destabilizing site neutral payment reductions it finalized in the CY 2019 OPPS rule.

Beginning in 2019, CMS will pay for clinic visit services described by HCPCS code G0463 furnished by excepted (grandfathered) off-campus provider-based outpatient departments at the Physician Fee Schedule relativity adjuster rate, *i.e.,* the same payment amount used to pay for services furnished by non-excepted (non-grandfathered) off-campus provider-based outpatient departments.

In the proposed rule, CMS asked if certain rural hospitals should be exempt from this policy change. In its comment letters, the Coalition urged CMS to exempt SCHs (urban and rural), RRCs and MDHs not only from this policy change, but also from the original policy that reduced payment for non-excepted sites.

As CMS referenced in the proposed rule, applying this limitation to rural hospitals could further exacerbate the recent reports of hospital closures in rural areas. As previously stated, a large majority of rural hospitals are already financially vulnerable due to a number of factors, including payment inadequacy and uncertainty.

In proposing the policy change, CMS cited concerns about hospitals purchasing additional physician practices to bill for physician services at OPPS payment rates as one reason for this

change. CMS should not have the same concern with respect to SCHs, RRCs and MDHs where expanding services to underserved rural areas also is desirable, and perhaps trumps other concerns held by CMS.

While, the final rule included a two-year phase-in of the policy, which helps modestly, the agency proceeded with implementation without adequately studying and addressing the concerns raised by rural stakeholders. The final rule stated that "…we sought public comment on whether there should be exceptions from this policy for rural providers, such as those providers that are at risk of hospital closure or those providers that are sole community hospitals. Taking into consideration the comments regarding rural hospitals, we believe that implementing this policy with a 2-year phase-in will help to mitigate the immediate impact on rural hospitals. We may revisit this policy to consider potential exemptions in the CY 2020 OPPS rulemaking."

CMS could have instead chosen to delay implementation in rural areas to allow time to test this new policy on non-rural hospitals, thereby examining data before deciding whether to apply it to RRCs, SCHs and MDHs. At the very least, CMS could have offered some data about the prevalence of rural hospitals acquiring physician practices before applying this policy to rural providers. Despite professing to examine policy through a rural lens, CMS provided no evidence that it did so in this instance. We believe this type of data-driven policy is essential in guaranteeing a strong rural health care safety net.

We also request that the agency examine the implications of MS-DRG recalibration policies on RRCs, SCHs and MDHs. This disturbing trend is further challenging rural hospitals, and especially RRCs, SCHs and MDHs. According to Table 1, the Impact Analysis of Proposed Changes (83 *Fed. Reg.* 20,603 *et seq.*), rural hospitals are disproportionately disadvantaged by the budget neutrality adjustments CMS uses when implementing and reconciling MS-DRG changes from year-to-year.

For FY 2019, CMS estimated that this adjustment will be neutral for urban hospitals, but cause a 0.3 percentage point payment reduction for rural hospitals. The impacts for certain categories of rural hospitals are even greater, including 0.4 percentage points for SCHs, and 0.5 percentage points for MDHs and MDHs that also have RRC status. As if this is not troubling enough, this has been a consistent trend in recent years, serving to perpetuate the gap between urban and rural hospitals and further threatening the gap between urban and rural providers.

| Weights and DRG Changes with Application of Recalibration Budget Neutrality Values Comparison Between Urban and Rural Hospitals From 2014 to 2018[3] | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 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 2014 Final Rule |
| 2015 | 0 | -0.2 | 0 | -0.2 | -0.3 | -0.3 | -0.3 | IPPS 2015 Final Rule Correction Notice |
| 2016 | 0 | -0.2 | -0.1 | -0.3 | -0.3 | -0.3 | -0.3 | IPPS 2016 Final Rule Correction |
| 2017 | 0 | -0.4 | -0.1 | -0.3 | -0.6 | -0.3 | -0.6 | IPPS 2017 Final Rule Correction |
| 2018 | 0 | 0.1 | 0.1 | -0.2 | | -0.1 | | IPPS 2018 Final Rule Correction |
| 2019* | 0 | -0.3 | 0 | -0.4 | -0.5 | -0.2 | -0.5 | IPPS 2019 Proposed Rule |
| Total | 0 | -1.4 | -0.2 | -2 | -2.4 | -1.5 | -2.2 | |

*proposed rule

The Coalition urges CMS to examine this phenomenon and consider making an adjustment, if deemed appropriate. CMS has committed itself to supporting rural hospitals, and 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).

While we have many additional ideas on how CMS can and should increase payment in targeted ways to buttress rural hospitals, the agency could start modestly by simply not cutting payments. The Coalition respectfully request that CMS carefully reconsider the policies set forth above and exempt RRCs, SCHs and MDHs from the destabilizing OPPS site neutral payment reductions applied to off campus provider-based entities, as well as examine the implications of MS-DRG recalibration policies on RRCs, SCHs and MDHs.

**Avoiding Artificial Distinctions**

The Coalition also requests that CMS revisit its use of what we call "artificial" distinctions. Artificial, in that there is no apparent data analysis behind these distinctions.

The primary example of this is the distinction CMS repeatedly makes between rural and urban SCHs when making policy decisions, such as in the application of the exception to the 340B payment cuts and in the application of the 7.1 percent adjustment under the OPPS. The Coalition

understands that CMS uses Metropolitan Statistical Areas (MSAs) to delineate between urban and rural areas. While we appreciate the need to distinguish urban and rural for a number of payment and policy mechanisms, and accept that MSAs provide a ready tool for this purpose, MSAs are not the most precise tool for characterizing urban and rural areas. Given that MSAs use counties as building blocks, many "urban" areas are as rural as the most isolated frontier area. In fact, to be an *urban* SCH, a hospital has to be even further (35 miles) from another hospital to qualify. Currently, there are 78 urban SCHs in 38 states.[3] Some of these (36) have undergone urban-to-rural reclassification under the process described at 42 C.F.R. § 412.103 to retain rural status and access to these protections, but 42 have not sought or not been able to avail themselves of this process, and so remain urban and without these protections.

Using MSAs to identify urban and rural areas is particularly problematic in the western United States where there are many very large counties that comprise MSAs (see, for example, San Bernardino County in California and Pima County in Arizona). There are instances where an SCH is designated urban by CMS, but is actually a considerable distance from the nearest urbanized area. For example, Verde Valley Medical Center (Provider Number 03-0007) is located in Prescott, AZ and is considered an urban SCH. However, the closest urbanized area with more than 40,000 people is Flagstaff, AZ, which is nearly 100 miles away.[4] Verde Valley has undergone an urban-to-rural reclassification, so it is eligible for these protections. Hospitals like South Texas Regional Medical Center (45-0165) in Jourdanton, Texas or Grady Memorial Hospital (37-0054) in Chickasha, Oklahoma have not undergone urban-to-rural reclassification, and so are not eligible for these protections. These are not urban areas by most reasonable standards, except the MSA standard.

Further, urban and rural SCHs serve very similar patient populations, face the same financial challenges, and both play an essential role as safety net providers in rural communities. By relying on MSA assignment, CMS perpetuates the shortcomings of using MSAs as the means to differentiate between rural and urban SCHs. Moreover, CMS is distorting its own policies by incentivizing hospitals to undergo urban-to-rural reclassification to take advantage of these protections. <u>While there are a relatively small number of urban SCHs, they should be afforded the same benefits of their rural counterparts</u>. To conclude, despite repeated efforts to raise these concerns, that because these hospitals are in urban area they are somehow less deserving of protections the agency believes are needed for rural SCHs, is failing to fulfill on the agency's pledge to protect rural communities.

Similarly, RRCs and MDHs—like SCHs—play an important role in the rural health care safety net, and exhibit many of the same vulnerabilities as SCHs. Numerous studies, including a recent government study by HHS, confirm that rural hospitals tend to have much thinner Medicare and overall margins than their urban counterparts, as well as much higher Medicare and Medicaid exposure.[5] According to the National Rural Health Association (NRHA), more than 75 rural

[3] Centers for Medicare & Medicaid Services. FY 2018 IPPS Impact File, September 29, 2017.
[4] Metropolitan and Micropolitan Statistical Areas of the United States and Puerto Rico, US Census Bureau. July 2015. https://www2.census.gov/geo/maps/metroarea/us_wall/Jul2015/cbsa_us_0715.pdf
[5] Rural Hospital Participation and Performance in Value-based Purchasing and Other Delivery System Reform Initiatives, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Issue Brief, October 19, 2016.

hospitals have closed since 2010, and many more—673, according to NRHA—are vulnerable to closure. These vulnerabilities represent more than one-third of the rural hospitals in the U.S., and up to 11.7 million rural patients could lose direct access to care should this trend continue.

The Medicare Payment Advisory Commission (MedPAC) highlighted the impact of these closures in its June 2016 Report to Congress: "…rural hospital closures have increased in the last three years. Some closures reflect excess capacity, but in other instances, the closed hospitals were the sole provider of emergency services in the area. From March 2013 through March 2016, 43 rural hospitals closed…While 27 of the closures were less than 20 miles from the nearest hospital, 13 were 20 to 30 miles from the nearest hospital and 3 were over 30 miles from the nearest hospital."[6]

These statistics reinforce the reasons CMS should seek to provide continued support for rural facilities—especially SCHs, ***and*** RRCs and MDHs—to ensure continued access to needed health care in rural America. To date, the agency has provided no data-driven basis for extending protections to rural SCHs, while not likewise making them available to RRCs and MDHs. We encourage CMS to avoid the continued use of these artificial distinctions between rural safety net providers.

CMS could take two steps to move in this direction. First, with respect to the Medicare OPPS 340B payment cuts, we have cited numerous reasons why CMS should insulate urban SCHs, RRCs and MDHs, and CMS has articulated no policy justification for why it would favor rural SCHs over urban SCHs, RRCs and MDHs in this policy. CMS should therefore extend the rural SCH exception to the Medicare OPPS 340B payment reductions to hospitals with urban SCH status, RRC status and MDH status.

Likewise, CMS should also conduct a review to determine whether the 7.1 percent OPPS adjustment afforded to rural SCHs should also be extended to urban SCHs, RRCs and to MDHs. CMS has the authority to extend this same protection to urban SCHs, RRCs and MDHs. The statutory command that was the basis for this adjustment directed CMS to study the costs incurred by hospitals located in rural areas as compared to those in urban areas, and to make an appropriate adjustment for rural hospitals based on those findings. CMS conducted that study and made the adjustment. CMS is not precluded by this language from conducting a follow-up study that examines these other facilities as cohorts, and from making a similar adjustment, especially since these facilities are by definition located in rural areas.

Urban SCHs, RRCs and MDHs, like rural SCHs, serve challenging rural patient populations, face financial uncertainty, and play an essential role as safety net providers in rural communities and for the Medicare program in particular. For these reasons, we believe it would be appropriate for CMS to study the extension of the 7.1 percent OPPS adjustment to these facilities.

[6] Report to the Congress: Medicare and the Health Care Delivery System, Medicare Payment Advisory Commission, June 2016, page 208.

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We are hopeful that the suggestions we provided during the December 10 listening session and elaborated upon in this letter will result in tangible actions by CMS.

The Coalition thanks you again for the opportunity to be part of this ongoing conversation, and we look forward to continuing an open dialogue with CMS on the important issue of ensuring a strong rural health care infrastructure.

Please do not hesitate to contact me at 202.204.1457 or ezimmerman@mcdermottplus.com if you have any questions.

Sincerely,

Eric Zimmerman