June 7, 2023

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Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: CMS-1785-P

Re: Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership [CMS-1785-P]

Dear Administrator Brooks-LaSure:

The Alliance for Rural Hospital Access appreciates the opportunity to comment on the proposed Hospital Inpatient Prospective Payment System (IPPS) rule for FY 2024.

The Alliance is comprised of hospitals designated as Medicare-Dependent Hospitals (MDHs), Rural Referral Centers (RRCs) and Sole Community Hospitals (SCHs) under the Medicare program. 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.

The Alliance is submitting comments specifically on how the Centers for Medicare & Medicaid Services (CMS) pays SCHs and MDHs that have teaching programs or that are disproportionate share hospitals (DSH). Specifically, **the Social Security Act commands CMS to make additional payments to such hospitals, beyond the hospital-specific rate**. CMS is not presently doing this. We believe that is inconsistent with the Social Security Act, and that CMS should change how it applies these adjustments to these hospitals effective in FY 2024.

Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 Through 413.83)

Section §1886(d)(5)(B) of the Social Security Act states, "[CMS] shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education…," without exception. SCHs and MDHs are subsection (d) hospitals. If they incur indirect costs of medical education, they must be given "an additional payment amount."

Commenters have previously urged CMS to make additional payments to hospitals paid on the basis of their hospital-specific rate. CMS has responded, "SCHs that are paid on the basis of their hospital-specific rate do not receive a separate IME add-on payment for Medicare Part A patient discharges because, generally the hospital-specific rate already reflects the additional costs that a teaching hospital incurs for its Medicare Part A patients." *See*, 79 *Fed. Reg.* 49,854, 50,002 (Aug 2022, 2014). We do not agree that the hospital-specific rate "already reflects the additional costs that a teaching hospital incurs," and believe that CMS is acting contrary to the unambiguous text of the statute. The statute is clear on its face, CMS must "provide for an additional payment amount."

Further, the statute prescribes how CMS is to provide for "the additional payment amount." Congress has articulated very specific formulae for making the additional payment, and has refined the statutory formulae multiple times, with *increasing specificity*. Congress has been clear and prescriptive. The statute leaves CMS no authority to deviate from those formulae and to determine its own methodology for providing the "additional payment amount."

In addition to not following the plain language of the statute, CMS's reasoning for deviating from those commands also is flawed. Hospital-specific rates are derived from hospital cost reports in specified years. For SCHs those years are 1982, 1987, 1996 or 2006; for MDHs, those years are 1982, 1987 or 2002. It is conceivable that hospitals with teaching programs in years that predated their hospital-specific rate base year had *some* of those costs reflected in their hospital-specific rates. Hospitals that developed teaching programs in years *after* their hospital-specific rate base year could not have those costs reflected in their hospital-specific rates. And any hospital that expanded its teaching program after its base year also does not have those costs reflected in its hospital-specific rate.

There also is a compelling policy rationale for CMS to apply the statute as written. SCHs are often the sole source of care within and around a community. MDHs are by definition vital providers to the Medicare program. Many beneficiaries who live in rural communities depend on these facilities for a full complement of health care services, from primary care to sophisticated inpatient treatment. More and more rural hospitals are struggling and closing, causing access problems for residents of rural communities. When an MDH or SCH closes, the consequences for the community may be grave.

Over 100 rural hospitals closed from January 2013-February 2020. When rural hospitals close, people living in areas who receive care from them must travel farther to get the same services—about 20 miles farther for common services like inpatient care. People have to travel even

farther—about 40 miles—for less common services like alcohol or drug abuse treatment.[1] According to 2023 data from the Center for Healthcare Quality & Payment reform, more than 600 rural hospitals—nearly 30% of all rural hospitals in the country—are at risk of closing because of the serious financial problems they are experiencing.[2]

Moreover, rural health care workforce shortages are well-documented. SCHs and MDHs can help alleviate physician shortages by establishing teaching programs, if they have adequate resources to do so. Specifically, SCHs and MDHs are well-situated to host residency programs, but SCHs and MDHs paid on the basis of their hospital-specific rate are financially disincentivized to establish such programs.

SCHs and MDHs—which comprise nearly 80% of IPPS hospitals eligible to establish training programs in rural communities—should receive the same incentives and financial buffer as hospitals paid under the federal rate. IME payments are necessary to establish and operate rural-based residency training programs.

Rural communities struggle to recruit and retain physicians, including most notably primary care physicians. Studies have shown that training physicians in rural areas increases the likelihood those physicians will practice in a rural community.[3] Yet, according to the Government Accountability Office, only two percent of residency training occurs in rural areas.[4]

The Department of Health and Human Services (HHS) and public health advocates have recommended that more physician training be localized in rural areas. The Council on Graduate Medical Education[5] in an April 2022 report to the Secretary of HHS and Congress recommended that CMS "eliminate regulatory and financial barriers that inhibit the development of rural residency programs" and "offer Medicare… exceptions for sponsoring institutions starting new rural-based training programs…in needed…geographic areas."[6]

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[1] *Rural Hospital Closures: Affected Residents Had Reduced Access to Health Care Services*. January 2021. https://www.gao.gov/products/gao-21-93

[2] *Rural Hospitals At Risk of Closing*. https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

[3] Hempel S, Maggard Gibbons M, Ulloa JG, Macqueen I, Miake-Lye I, Beroes J, et al. Rural Healthcare Workforce: A Systematic Review. VA Evidence-based Synthesis Program Reports. Washington, DC: Department of Veterans Affairs; 2015. 79.1.

[4] United States Government Accountability Office. Graduate Medical Education: Programs and Residents Increased during Transition to Single Accreditor; Distribution Largely Unchanged. GAO-21-329, (April 2021) p.24.

[5] COGME was authorized by Congress to provide advice and recommendations to the Secretary and Congress on physician workforce trends, training issues, and financing policies.

[6] Council on Graduate Medical Education, Twenty-Fourth Report to the Secretary of the U.S. Department of Health and Human Services and the U.S. Congress, "Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities," (April 2022) p. 12.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024 (§ 412.106)

Substantially similar statutory and policy arguments apply with respect to DSH adjustments. Section 1886(d)(5)(F) of the Social Security Act provides, "…the Secretary shall provide…for an additional payment amount for each subsection (d) hospital which…" meets criteria specified in the statute. According to this language, all subsection (d) hospitals that meet the criteria must receive an "additional payment amount." As with IME adjustments, this subparagraph provides very specific formulae for determining the "additional payment amount," and even provides very specific formulae applicable to SCHs and MDHs. CMS may not deviate from the unambiguous text of the statute and forego making the "additional payment amount." Moreover, because the cost of uninsured patients is not included in the federal DRG rate or SCH and MDH hospital-specific rates, it is not credible to say that a hospital's additional costs of treating this patient population are reflected in the hospital-specific rate. Thus, SCHs and MDHs deserve the DSH add-on to their hospital-specific rates just as other hospitals receive an add-on to the federal DRG rate.

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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