



August 18, 2023

**VIA REGULATIONS.GOV**

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Ave SW  
Washington, DC 20201

**Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Payment for Intensive Outpatient Services in Rural Health Clinics, Federally Qualified Health Centers, and Opioid Treatment Programs; Hospital Price Transparency; Changes to Community Mental Health Centers Conditions of Participation, Proposed Changes to the Inpatient Prospective Payment System Medicare Code Editor; Rural Emergency Hospital Conditions of Participation Technical Correction [CMS-1786-P]**

Dear Administrator Brooks-LaSure:

On behalf of the Alliance for Rural Hospital Access (ARHA, or the Alliance), please accept these comments on the proposed Hospital Outpatient Prospective Payment System (OPPS) rule for CY 2024.

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. MDHs, RRCs and SCHs provide rural populations with local access to a wide range of health care services. In doing so, they 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 the Centers for Medicare and Medicaid Services (CMS) have reconfirmed their commitment to these hospitals repeatedly over the years by providing new protections to ensure their viability and to ensure patient access to hospital services in rural communities. ARHA and its members share this goal of ensuring that federal hospital payment policies recognize the unique role and important contributions these hospitals bring to the Medicare program and its beneficiaries. Consistent with this mission, ARHA appreciates the opportunity to provide CMS with the comments set forth in this letter.

## A. Executive Summary

The Alliance is submitting comments on two proposals, and we urge CMS to take the following actions:

- **Proposed OPPS Payment for Hospital Outpatient Visits and Critical Care Services**
  - Continue to exempt services furnished by excepted off-campus provider-based departments of rural SCHs.
  - Extend this exemption to *urban* SCHs, and MDHs.
  
- **Proposed Adjustment for Rural SCHs and Essential Access Community Hospitals under Section 1833(t)(13)(B) of the Social Security Act (the Act) for CY 2024**
  - Extend the payment adjustment to *urban* SCHs.
  - Study the appropriateness of making a similar payment adjustment for MDHs.

## B. Background on Rural Hospital Designations

**Medicare Dependent Hospitals:** The MDH program was established by Congress 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. To qualify as an 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.

**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 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 providing access to care. 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.

### **C. Proposed OPSS Payment for Hospital Outpatient Visits and Critical Care Services – Continued Exemption of Rural SCHs From the Method To Control Unnecessary Increases in the Volume of Clinic Visit Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)**

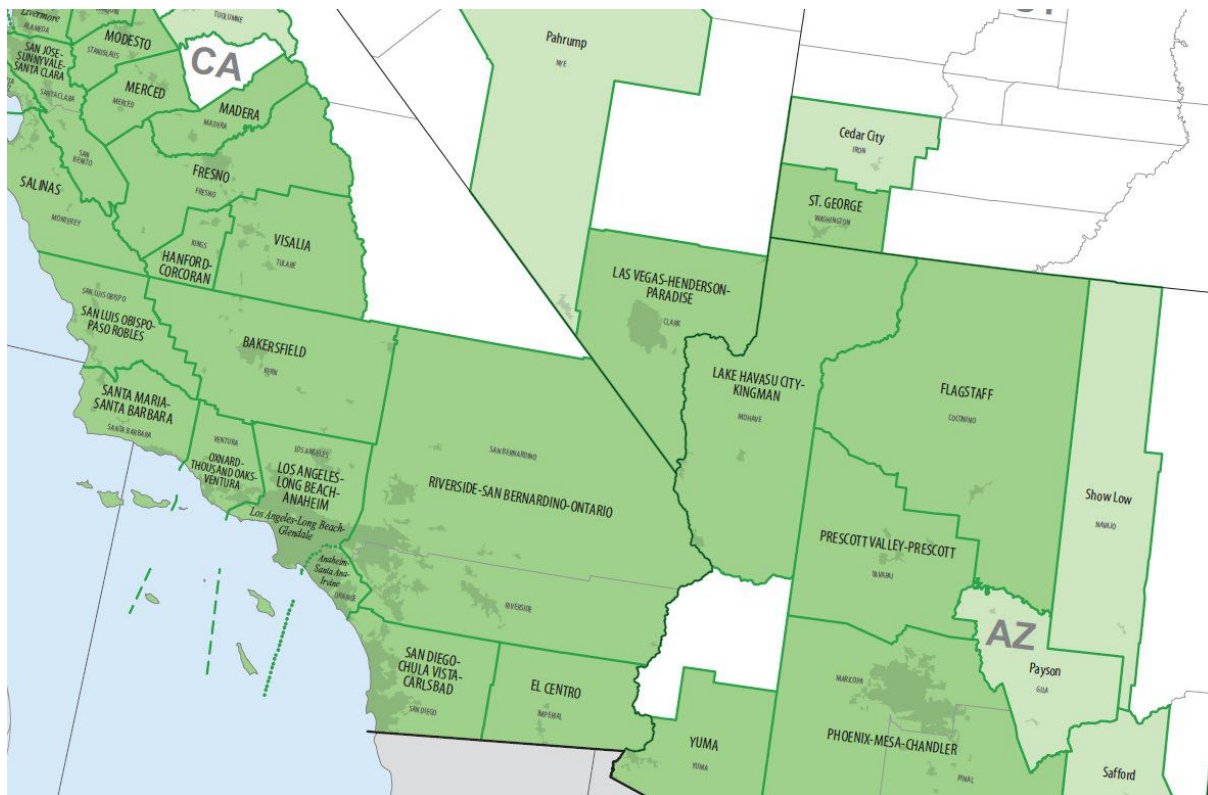
In CY 2019, CMS began implementing a policy to pay for clinic visit services described by HCPCS code G0463 furnished by excepted (grandfathered) off-campus provider-based outpatient departments at the Physician Fee Schedule (PFS) relativity adjuster rate, *i.e.*, the same payment amount used to pay for services furnished by non-excepted (non-grandfathered) off-campus provider-based outpatient departments. As part of that rulemaking, CMS echoed ARHA’s concerns about access to care, especially in rural areas where access issues may be more pronounced than in other areas of the country. The Alliance repeatedly urged CMS to exempt SCHs, MDHs and RRCs from this policy, but CMS finalized the policy for all excepted off-campus provider-based outpatient departments.

In CY 2023, CMS continued the policy of paying the PFS-equivalent rate of 40 percent of the OPSS payment rate for hospital outpatient clinic visits coded under HCPCS G0463 when delivered by a previously excepted off-campus provider-based department. In addition, CMS proposed and finalized a provision to exempt services furnished by excepted off-campus PBDs of *rural* SCHs, and sought input on other types of rural hospitals that it should consider exempting. In its CY 2023 comments, the Alliance expressed strong support for the rural SCH exemption, and also urged CMS to extend the same relief to urban SCHs and MDHs

In the current CY 2024 rule, CMS proposes to continue to exempt excepted off-campus PBDs of rural SCHs from the clinic visit payment policy and notes it will continue to monitor the effect of this change in Medicare payment policy. **The Alliance continues to strongly support the continuation of this policy for rural SCHs, and again urges CMS to extend this same relief to urban SCHs, along with MDHs.** Our reasoning follows.

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, MSAs are not the most precise tool for characterizing urban and rural areas. Given that MSAs use counties as building blocks, many areas are designated as “urban” because they have a single urbanized area. But if the county is unusually large, significant portions of that county may be as rural as the most isolated frontier area.

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 Flagstaff and Pima Counties in Arizona).



There are instances where an SCH is designated urban by CMS, but the hospital is actually a considerable distance from the nearest urbanized area. Verde Valley Medical Center (Provider Number 03-0007), for example, 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.<sup>1</sup> Verde Valley has undergone an urban-to-rural reclassification, so it is eligible for these protections. Hospitals like Methodist Hospital South (45-0165) in Jourdanon, Texas 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.

Currently, there are 93 SCHs located in urban designated geographic Core Based Statistical Areas.<sup>2</sup> Some 78 of these 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. Others have not sought or have not been able to avail themselves of this process, and so remain urban and without these protections.

CMS should extend this exemption to urban SCHs because using MSAs to determine urban and rural areas is imprecise, and distinguishing between urban and rural SCHs when applying payment policy unfairly disadvantages urban SCHs that are the sole source of hospital services in their communities, like their rural counterparts. Urban SCHs are serving communities that are truly rural in character. In fact, as CMS knows, to be an *urban* SCH, a hospital has to be even further (35 miles) from another hospital to qualify than if it were a *rural* hospital. CMS also can

<sup>1</sup> 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](https://www2.census.gov/geo/maps/metroarea/us_wall/Jul2015/cbsa_us_0715.pdf)

<sup>2</sup> Centers for Medicare & Medicaid Services. FY 2024 IPPS Final Rule Impact File, August 2023.

reduce incentives to undergo urban-to-rural reclassification to take advantage of these protections.

CMS also should do this to protect access to hospital care in these communities by protecting the hospitals that serve these communities. Rural hospitals are closing at alarming rates, and applying the PFS relativity adjuster to rural hospitals may be a contributing factor. A large majority of rural hospitals are already financially vulnerable due to a number of factors, including payment inadequacy and uncertainty. The COVID-19 pandemic has compounded these vulnerabilities. When looking at the types of hospitals that comprise the ARHA, data from the [North Carolina Rural Health Research Program](#) show that a total of 50 MDHs, RRCs and SCHs have closed since 2005.

As set forth in the May 2022 Bipartisan Policy Center (BPC) [report](#) titled “The Impact of COVID-19 on the Rural Health Care Landscape,” rural hospitals continue to face challenges that threaten their financial well-being. The report notes that, although federal support during the pandemic has temporarily helped many vulnerable hospitals, once the federal public health emergency ends and this financial relief is no longer available, many of the rural hospitals that were struggling before the pandemic will again be at risk of closure—unless additional actions are taken to shore up these facilities.

Rural SCHs, urban SCHs and MDHs have below average patient care margins. On average, patient care margins<sup>3</sup> are negative for rural SCHs, urban SCHs and MDHs.

Hospital Type	Patient Care Margin
	Mean
Rural Sole Community Hospital	-2.4%
Urban Sole Community Hospital	-1.7%
Medicare Dependent Hospital	-3.0%
All other OPPS Hospitals	0.5%

*Note: McDermottPlus’ analysis of Medicare Hospital Cost Reports with cost report ending date before the pandemic started in April 2020. Patient care margins are defined as net income from service to patients divided by patient care revenues. We excluded hospitals with missing Cost Reports data and removed highest and lowest 5% of data as outliers.*

GAO likewise found that Medicare profit margins and total hospital profit margins declined for MDHs from fiscal year 2011 through 2017, from -6.9 percent to -12.9 percent and 1.6 percent to -0.2 percent, respectively.<sup>4</sup> The degree to which Medicare margins declined for MDHs during this time period (6 percentage points) was greater than the degree to which they declined for rural hospitals (3.8 percentage points) and all hospitals (2.5 percentage points). The number of Medicare-Dependent Hospitals declined 28 percent from 193 hospitals in fiscal year 2011 to 128

<sup>3</sup> McDermottPlus’ analysis of Medicare Hospital Cost Reports with cost report ending date before the pandemic started in April 2020. Patient care margin is calculated by dividing net income from services to patients by total patient care revenues. We excluded hospitals with missing Cost Reports data and removed highest and lowest 5% of data as outliers.

<sup>4</sup> GAO, Information on Medicare-Dependent Hospitals, GAO-20-300 (Washington, D.C.: February, 2020). <https://www.gao.gov/assets/gao-20-300.pdf>

hospitals in 2017 as hospitals became ineligible for MDH status, and 16 closed between 2013 and 2017, or experienced other changes.<sup>5</sup>

Supporting SCHs and MDHs in this way would help secure access for Medicare beneficiaries and Medicaid enrollees in underserved communities. Rural SCHs, urban SCHs and MDHs are often the sole health care providers in isolated areas where health care access is lacking. Our analysis shows that 56 percent of rural SCHs, 73 percent of urban SCHs, and 60 percent of MDHs are located in at least one type of medically underserved area as defined by Health Resources and Services Administration Medically Underserved Area designations.

Hospital Type	Hospital Count	Hospitals in MUA	Percent
<b>Rural Sole Community Hospital</b>	448	251	56%
Urban Sole Community Hospitals redesignated as rural under § 412.103	77	33	43%
Urban Sole Community Hospitals ( <i>not redesignated as rural</i> )	15	11	73%
<b>Medicare Dependent Hospital</b>	169	102	60%

M+ Analysis of Medically Underserved Area (MUA)<sup>6</sup> designations from the Health Resources and Services Administration.

Moreover, rural SCHs, urban SCHs and MDHs serve a higher proportion of Medicare and Medicaid beneficiaries. More than half of their inpatient days come from Medicare, Medicaid or Children’s Health Insurance Program (CHIP) beneficiaries. The median share of Medicare, Medicaid and CHIP inpatient days for rural SCHs, urban SCHs and MDHs, is 52 percent, 58 percent and 54 percent respectively, compared to 42 percent for all other outpatient providers.<sup>7</sup>

Hospital Type	Share of Medicare, Medicaid and CHIP from Total Inpatient Days
	Median
Rural Sole Community Hospital	52%
Urban Sole Community Hospital	58%
Medicare Dependent Hospital	54%
All other OPPS Hospitals	42%

M+ Analysis of Medicare Cost Reports ending before the pandemic started in April 2020. Excludes hospitals with missing Cost Reports data.

Extending this exemption to MDHs and urban SCHs would add nominally to the cost. For CY 2023, CMS estimated that the proposed exemption for rural SCHs “would increase OPPS spending by approximately \$75 million in CY 2023 compared to spending if [CMS] did not implement this exemption...” 87 *Fed Reg.* at 44698 (July 26, 2022).

<sup>5</sup> GAO, Rural Hospital Closures: Number and Characteristics of Affected Hospitals and Contributing Factors, GAO-18-634 (Washington, D.C.: Aug. 29, 2018). <https://www.gao.gov/products/gao-18-634>

<sup>6</sup> A hospital is determined to be in a Medically Underserved Area (MUA) if the hospital’s main address meets the requirement of at least one MUA designation type based on either geographic area, specific population characteristics of that geographic area (i.e., homeless population), or a governor’s designation. For detail, please refer to the Health Resources and Services Administration website: <https://bhwh.hrsa.gov/workforce-shortage-areas/shortage-designation>

<sup>7</sup> McDermottPlus’ analysis of Medicare Hospital Cost Reports with cost report ending date before the pandemic started in April 2020. We excluded hospitals with missing Cost Reports data.

Medicare's CY 2024 OPPS Impact File shows 468 hospitals with SCH status and 177 with MDH status. Of the 468 hospitals with SCH status, 374 are geographically located in a rural area; 93 are geographically located in an urban area, but 78 of those hospitals undergo urban-to-rural reclassification pursuant to 42 C.F.R. § 412.103 to be eligible for benefits CMS has chosen to confer only on rural SCHs; 15 of those hospitals have not undergone urban-to-rural redesignation either because they are ineligible or it is impractical to do so. Also exempting from the PFS-equivalent rate services furnished by MDHs and urban SCHs would benefit 192 (177 MDHs and 15 urban SCHs) mostly rural hospitals, all of which have earned special Medicare safety net designation because of the role they play in providing access to hospital care for Medicare beneficiaries. Our analysis estimates that exempting urban SCHs and MDHs as suggested will increase Medicare spending by \$0.9 million and \$7.8 million, respectively, on top of the \$75 million that CMS predicts to be the amount by which exempting rural SCHs from the site neutral policy would increase spending in CY 2023.<sup>8</sup> In other words, CMS could buttress a small number of additional vulnerable Medicare safety net hospitals for a nominal additional cost, approximately \$8.7 million, or \$84 million in the aggregate.

**For these reasons, we urge CMS to finalize the continuation of its policy to exempt rural SCHs from the site neutral policy, and we urge CMS to extend the same relief to urban SCHs and MDHs.**

#### **D. Proposed Adjustment for Rural SCHs and Essential Access Community Hospitals under Section 1833(t)(13)(B) of the Social Security Act (the Act) for CY 2024**

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,<sup>9</sup> that compared to urban hospitals, rural SCHs have substantially higher costs, and need a payment adjustment to be comparably treated under the OPPS. For CY 2024, CMS proposes to continue this payment adjustment for rural SCHs.

The Alliance supports this continuation and urges CMS to finalize it as proposed. We also urge CMS to take the following additional actions with respect to the policy.

##### **1. Extend the Adjustment to Urban SCHs**

CMS consistently makes this adjustment available only to rural SCHs because Congress directed CMS to study only rural hospitals. CMS should extend this adjustment to *urban* SCHs as well. As previously mentioned, there is no policy basis for distinguishing between urban and rural SCHs. CMS has historically used MSAs to differentiate urban and rural, which becomes problematic when applied to SCHs.

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<sup>8</sup> McDermottPlus' analysis of CY 2023 OPPS proposed rule data (2021 claims) ratesetting file.

<sup>9</sup> § 411(b), Pub. L. No. 108-173.

Both urban and rural SCHs serve challenging patient populations with higher rates of health disparities and poorer health outcomes. Both urban and rural SCHs face similar financial challenges leading to increasing rates of closures. Further, both urban and rural SCHs play an essential role as safety net providers in rural communities, with many residents relying on the hospital for a variety of health services from routine care to treatment for complex medical cases. **For these reasons, ARHA urges CMS to extend this adjustment to urban SCHs.**

CMS has the authority to extend this same protection to urban SCHs. 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 broader study not prompted by this section that examines urban SCHs as a cohort, and from making a similar adjustment to urban SCHs. We estimate that extending the 7.1 percent payment increase to urban SCHs would result in an additional \$16.8 million for these hospitals.<sup>10</sup>

## 2. Study the Appropriateness of Making a Similar Payment Adjustment for MDHs

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. As noted above, our analysis of Medicare Cost Report data demonstrates that mean patient care margins for MDHs are among the worst of all hospital cohorts. **For these reasons, the Alliance urges CMS to study whether it would be appropriate to extend a similar adjustment to MDHs.**

CMS has the authority to extend this same protection to 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 MDHs as a cohort, and from making a similar adjustment to MDHs, especially since MDHs also are by definition located in rural areas. We estimate that extending this adjustment to MDHs would provide an additional \$72.7 million to these facilities.<sup>11</sup>

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Thank you for your consideration of these comments. Please contact me at 202.204.1457 or [ezimmerman@mcdermottplus.com](mailto:ezimmerman@mcdermottplus.com) if you have any questions.

Sincerely,



Eric Zimmerman

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<sup>10</sup> McDermottPlus' analysis of 2019 Medicare FFS outpatient claims data. Impacts estimated in 2019 dollars.

<sup>11</sup> McDermottPlus' analysis of 2019 Medicare FFS outpatient claims data. Impacts estimated in 2019 dollars.