June 7, 2024

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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-1808-P

Re: Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes [CMS–1808–P]

Dear Administrator Brooks-LaSure:

The Alliance for Rural Hospital Access (the Alliance) appreciates the opportunity to comment on the proposed Hospital Inpatient Prospective Payment System (IPPS) rule for FY 2025.

The Alliance is comprised of hospitals designated as Medicare-Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs) and Rural Referral Centers (RRCs) under the Medicare program. MDHs, SCHs and RRCs provide rural populations with local access to a wide range of health care services. In doing so, MDHs, SCHs and RRCs 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.

Executive Summary

The Alliance urges CMS to take the following actions:

- **Proposed Transforming Episode Accountability Model (TEAM)**
  - CMS should limit TEAM participation only to hospitals in Metropolitan Statistical Areas.

- **Proposed Implementation of Revised Labor Market Area Delineations**

    - CMS should exercise its authority to provide a transition period for hospitals with MDH and SCH status that are affected by the updated labor market area delineations.
- **Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108); Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101)**
    - With CMS currently unable to assume the extension of the MDH program and low-volume adjustment beyond the first three months of FY 2025, CMS should explicitly clarify how it would handle the continuation of these programs should Congress enact year-end legislation to extend them, as is anticipated.
    - CMS should also take steps to expedite the retroactive restoration of these programs, should the congressional calendar result in a temporary lapse in authorization.

- **Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 Through 413.83)**
    - CMS should use its authority to ensure SCHs and MDHs paid using their hospital-specific rate receive indirect medical education (IME) adjustments, to encourage these hospitals to localize resident training in rural areas

- **Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2025 (§ 412.106)**
    - Similarly, CMS should use its authority to ensure SCHs and MDHs paid using their hospital-specific receive a DSH payment adjustment and an uncompensated care pool allocation, so that rural hospitals are reimbursed fairly for uncompensated care.

- **Impact of MS-DRG and Relative Weight Changes and Corresponding Budget Neutrality Adjustments**
    - CMS should examine how its current rate-setting methodology can contribute to disproportionate disadvantages to rural hospitals, including SCHs and RRCs.

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.

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.

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.

Proposed TEAM Model

CMS's proposal to implement a mandatory five-year episode-based payment model—the Transforming Episode Accountability Model (TEAM)—would require hospitals in selected geographic regions to be responsible for the total cost of care during and for 30 days after five different surgical procedures.

CMS proposes to require all hospitals in selected core-based statistical areas (CBSAs) to participate in TEAM. Notably, CBSAs include both Metropolitan Statistical Areas (MSAs), which have an urban core population of at least 50,000, and Micropolitan Statistical Areas (mSAs), which have an urban core population of at least 10,000 but less than 50,000.

CMS's proposed methodology for defining eligible areas would include rural hospitals. The Alliance thinks that CMS should not include rural hospitals in TEAM, and especially not hospitals with SCH and MDH status. Our reasoning for this recommendation follows.

CMS's FY 2024 Hospital IPPS Impact Files show there are 451 SCHs, and that 340 (75.4%) could be selected to participate in TEAM (the remaining 111 likely would be exempt because they are located outside of a CBSA or belong to a CBSA excluded from the model). There are 170 MDHs; 116 (68.2%) could be selected to participate in TEAM (the remaining 54 likely would be exempt because they are located outside of a CBSA or belong to a CBSA excluded from the model).

For the following reasons, the Alliance urges CMS to limit TEAM eligibility only to MSAs (rather than the larger proposed CBSAs, which also include mSAs).

- Rural hospitals generally—and SCHs and MDHs in particular—are financially stressed. Obligatory participation in TEAM would increase financial pressures for hospitals that would have to devote more resources to participation, and that may suffer reduced

payments resulting from poor performance. SCHs and MDHs are often operating on razor-thin margins, if they have positive margins at all. Mandatory participation could force some of these hospitals to further reduce services or close, which would negatively impact access to care in rural areas.

- Rural hospitals generally—and SCHs and MDHs in particular—are also ill-prepared to participate in TEAM. These hospitals handle very low volumes of the selected episodes and therefore do not have the experience or volume to adjust behaviors as envisioned by the proposed model. According to an analysis of Medicare's 100% inpatient and outpatient limited data set files with a discharge date from October 2021 through September 2022, rural hospitals averaged 130 instances of cases in one of the five selected episodes; urban hospitals by contrast averaged nearly 320 cases. While urban hospitals tend to be larger, and that size differential partly explains the volume differential, lower volumes and frequency means less experience with these cases, and volumes that may be too low to be expected to achieve the performance expectations set under TEAM.

- Rural hospitals generally—and SCHs and MDHs in particular—also often do not have robust care networks that are needed to succeed as TEAM participants. As proposed, CMS requires participating hospitals to include a referral to a primary care provider in hospital discharge planning for a TEAM beneficiary. To be effective in the model, hospitals would also likely need to form networks with post-acute care providers, among others. Many communities served by SCHs and MDHs are experiencing a shortage of primary care clinicians, which may make it difficult for participating hospitals to comply with the primary care referral requirement for reasons outside their control. Further, some rural communities simply do not have post-acute care providers. Those that do have limited options, and those post-acute providers may decline to collaborate with the hospitals in the ways that would be needed to succeed under TEAM.

For illustration, consider Port Angeles, Washington, circled below. Port Angeles is a mSA. Port Angeles is the Principal City. According to recent census data, approximately 20,000 people live in the town of Port Angeles, and approximately 78,000 people live in Clallam County. Clallam County spans more than 1,700 square miles.

Port Angeles is home to our Alliance hospital, Olympic Medical Center (500072). Olympic is a SCH with 67 operating beds and an average daily inpatient census of 36 patients. Port Angeles has a 25 percent chance of being selected to participate in TEAM.

- Olympic struggles financially. According to hospital sources, 84 percent of Olympic's patient service revenue comes from government payer sources (primarily Medicare, Medicaid and TRICARE). Olympic lost more than $40 million across 2022 and 2023. Prior to the pandemic, Olympic typically averaged slim 2 percent margins. Olympic may not be able to sustain the payment degradation that could result from TEAM participation.

- Olympic does not have meaningful volume in the episodes included in TEAM. Olympic performed 206 LEJR procedures in 2022, but performed only 75 surgical hip/femur fracture treatments and 37 major bowel procedures in 2022. Olympic does not provide coronary artery bypass graft surgeries or spinal fusions. Hospitals like Olympic do not have the volumes to sufficiently pursue efficiencies in these service lines.

- In the rural area that Olympic serves, there is limited post-acute capacity. There are two skilled nursing facilities and three inpatient rehabilitation hospitals in Olympic's service area. At any given time, Olympic has between six and 12 patients who cannot be successfully discharged because there is not post-acute capacity available locally, and sometimes even regionally. While these challenges can also exist in urban areas, they are more typical in rural areas where these types of services are less profitable and often difficult to staff.

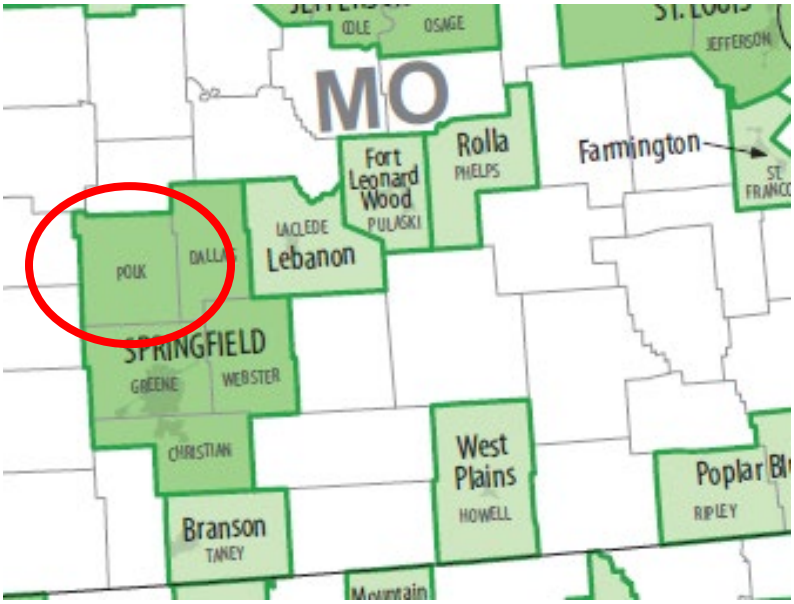
CMS has repeatedly expressed sensitivity to the plight of rural hospitals and its commitment to supporting rural hospitals. CMS should protect these financially vulnerable hospitals and the communities they serve.

<u>If CMS concurs, and exempts rural hospitals from TEAM, then CMS should defer to a hospital's Medicare payment location, rather than its physical location, given that some hospitals undergo</u>

urban-to-rural reclassification. These hospitals may be physically located in an urban area, but CMS treats them as being located in a rural area for all payment purposes. For programmatic consistency and other reasons, CMS should likewise consider these hospitals to be rural for purposes of exclusion from TEAM.

Many hospitals that undertake the urban-to-rural reclassification process do so because they are in areas that are truly rural in character, even though they may be in an MSA. The MSA building blocks that CMS uses to define urban and rural areas are crude and often classify hospitals as urban, even though the communities they are serve would be considered rural by anyone's standards.

Citizens Memorial Hospital (260195) is a good example of this phenomenon. Citizens is another Alliance hospital, located in Polk County, Missouri. Polk is in the Springfield MSA. Approximately 170,000 people live in the city of Springfield; only about 33,000 live in Polk County. The map below illustrates the distance between Polk and Springfield, and one can imagine that Polk is a rural area by most any definition. Citizens undergoes urban-to-rural reclassification to retain SCH status because it is lumped into the Springfield MSA, and would otherwise not qualify for SCH status.



If CMS were to limit to TEAM eligibility to hospitals in MSAs without factoring in a hospital's Medicare payment location (deferring instead to its physical location), hospitals that are physically located in MSAs, like Citizens, could be made to participate. If CMS wishes to exempt rural hospitals like Citizens, as we think it should, then CMS should not only limit eligibility to hospitals in MSAs, but also specify that that eligibility applies only to hospitals that are in MSAs for payment purposes (i.e., exempt from TEAM eligibility hospitals that reclassify to rural areas for payment purposes).

While limiting TEAM eligibility to MSAs—and clarifying that this eligibility applies only to hospitals that are located in MSAs for payment purposes—is the clearest, surest way that CMS can protect access to care in rural communities, an alternative option would be for CMS to explicitly carve out SCHs and MDHs from TEAM participation. Another alternative would be for CMS to make TEAM participation voluntary for SCHs and MDHs.

While CMS proposes to limit the lesser financial pressures available in Track 2 to rural and safety net hospitals, reasoning that doing so will make mandatory participation in TEAM financially tenable, this proposal does not go far enough in alleviating financial risk for vulnerable rural hospitals. If CMS is unwilling to protect rural hospitals by limiting eligibility to MSAs, or by carving out SCHs and MDHs, then, at the very least, CMS should allow for Track 1 participation for SCHs and MDHs throughout the duration of TEAM performance years, rather than mandatory Track 2 participation for performance years two through five. That said, *any* participation in TEAM, no matter which track, would still require struggling rural hospitals to devote already-scarce financial and administrative resources to the model, when they could be better used shoring up the provision of needed care to the communities they serve.

Proposed Implementation of Revised Labor Market Area Delineations

CMS proposes to adopt new geographical boundaries for hospitals based on the updated Office of Management and Budget (OMB) standards released in Bulletin No. 23–01 on July 21, 2023. As proposed, the changes would be effective for FY 2025. CMS notes that this will increase the integrity of the IPPS wage index system by creating a more accurate representation of current geographic variations in wage levels.

The Alliance generally supports CMS's proposal to implement these new labor market area delineations effective for FY 2025, and agrees that such updates maintain a more accurate and up-to-date payment system that reflects the reality of current labor market conditions. That said, due to the breadth of policies and regulations that rely on these delineations, and the many consequences for hospitals and other providers, we urge CMS to exercise its authority to provide a smooth transition for all affected providers.

In the proposed rule, CMS notes that its existing policy of a 5 percent cap on any decrease that hospitals may experience in their final wage index from the prior fiscal year will sufficiently mitigate significant disruptive financial impacts on hospitals that are negatively affected by the proposed adoption of the revised OMB delineations. For that reason, CMS does not propose a transition period for these hospitals.

The Alliance encourages CMS to reconsider this stance and instead—as it has done in the past—provide for transitional policies to mitigate negative financial impacts, particularly on vulnerable rural hospitals with MDH and SCH status.

Changes to hospital labor market configurations can cause significant changes in hospital wage index values and resulting inpatient payments. Further, these labor market reconfigurations also can affect eligibility for urban- and rural-specific classifications and programs, like SCHs and the

MDH program. Without a transition period, the proposed rule does not allow sufficient time for many hospitals that are already financially vulnerable to adapt to such changes.

The Alliance believes CMS should provide adequate time for hospitals to prepare. Hospitals confronting a geographic change from a rural area to an urban area need time to plan and adjust to the financial consequences of this change. Hospitals already have budgets and plans in place for FY 2025. It is particularly difficult for small, vulnerable hospitals such as MDHs and SCHs to adjust to changes in financial circumstances without an adequate transitional period.

For these reasons, the Alliance urges CMS to provide a transition period for hospitals with MDH and SCH status that are affected by the updated labor market area delineations.

Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program (§ 412.108); Proposed Payment Adjustment for Low-Volume Hospitals (§ 412.101)

The MDH program was created by Congress nearly 35 years ago to support hospitals that are dependent upon Medicare reimbursement and are 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 renewed periodically by Congress, and is due to expire on December 31, 2024, without further congressional action.

The Medicare low-volume hospital payment 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 also been renewed over the years—in tandem with the MDH program—and is also due to expire on December 31, 2024, without further congressional action.

The Alliance is working with Congress to advance legislation that would extend the MDH program and the low-volume adjustment (namely, S. 1110 and H.R. 6430). The loss of the MDH program and low-volume adjustment would have severe, adverse impacts on vulnerable rural hospitals and the communities they serve. In recent years, MDH and low-volume hospitals have operated under a near-constant uncertainty about the future of these programs. 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.

As hospitals finalize their FY 2025 budgets, they are not able to assume that these critical programs will be extended, and are therefore taking steps to account for this lost revenue and alleviate its impact.

The Alliance recognizes CMS regards these programs as ending on December 31, 2024, and that the agency typically does not create policy around actions Congress *may* take in the future. Nonetheless, the loss of these vital payments to a hospital and the community it serves can be profound, and there are steps CMS could take to minimize disruptions to beneficiary access to

care. The Alliance urges CMS to explicitly clarify how it would handle the continuation of these programs should Congress enact year-end legislation to extend them, as is anticipated.

In addition, CMS should also take steps to expedite the retroactive restoration of these programs, should the congressional calendar result in a temporary lapse in authorization. Past retroactive restorations have seen delays that caused significant cash flow problems to affected hospitals. If Congress again acts to extend these programs, but does not do so until after the December 31, 2024, expiration date, the Alliance implores 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.

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

The Alliance believes that the Social Security Act commands CMS to make additional payments to SCHs and MDHs that have teaching programs, beyond the hospital-specific rate. CMS is not presently doing this and the Alliance urges CMS to change how it applies these adjustments to these hospitals effective in FY 2025.

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).

The Alliance does 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 specific formulae for making the additional payment, and has refined the statutory formulae multiple times, with *increasing specificity*. Congress has been clear and prescriptive, and 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. Beneficiaries who live in rural communities often depend on these facilities for a full complement of health care services, from primary care to sophisticated inpatient treatment. Rural hospitals continue to struggle financially, and when an MDH or SCH closes, the consequences for the communities they serve may be grave.

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 hospitals eligible to establish training programs in rural communities—should receive the same incentives and financial buffer as hospitals paid under the federal rate. Based on CMS cost report data, 58% of SCHs and 46% of MDHs are paid on the basis of their hospital-specific rate. This formula for SCHs and MDHs should not disqualify the hospital from receiving full IME payments as they would under the federal rate formula. This full federal funding of DME and IME payments is necessary to establish and operate rural-based residency training programs.

The Alliance urges CMS to use its authority to ensure SCHs and MDHs paid using their hospital-specific rate receive IME adjustments, to encourage these hospitals to localize resident training in rural areas.

Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2025 (§ 412.106)

Similarly, the Alliance believes that Social Security Act commands CMS to make additional payments to SCHs and MDHs that are DSH hospitals, beyond the hospital-specific rate. CMS is not presently doing this and the Alliance urges CMS to change how it applies these adjustments to these hospitals effective in FY 2025.

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.
The Alliance urges CMS to use its authority to ensure SCHs and MDHs paid using their hospital-specific receive a DSH payment adjustment and an uncompensated care pool allocation, so that rural hospitals are reimbursed fairly for uncompensated care.

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

Over the past decade, the Alliance periodically commented on the impact of 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—on rural hospitals.

From FY 2014 through FY 2021, there was an ongoing, concerning trend in which rural hospitals were systematically and disproportionately disadvantaged by annual MS-DRG changes. More recently, the trend of rural hospitals being disproportionately, negatively impacted by these adjustments appeared to be moderating. CMS's impact tables in the FY 2022 and FY 2023 proposed IPPS rules showed rural hospitals at near parity with urban hospitals with respect to impacts resulting from the MS-DRG changes.

At the time, the Alliance commented that, while it was pleased to see these moderating impacts, it was not aware of any specific steps CMS took to fix this longstanding issue. Rather, it appeared that those years had simply been less disadvantageous for rural hospitals and, as a result, the Alliance expressed ongoing concern that the systemic methodologies CMS uses to make these adjustments could cause adverse impacts again in the future.

Unfortunately, this concern appears to have been well-founded, as the impact tables in the current FY 2025 proposed rule again show that rural hospitals are being disproportionately, negatively impacted by annual MS-DRG changes:

Hospital Type	Proposed FY 2025 Weights and DRG Changes with Application of Budget Neutrality
All Urban	0.0
All Rural	-0.4
RRC	-0.1
SCH	-0.6
RRC and SCH	-0.4

The return of these negative impacts further exacerbates the Alliance's overall, ongoing concern about the long-term sustainability and viability of its member hospitals—and *all* rural hospitals—and their ability to serve vulnerable communities.

CMS has repeatedly committed itself to supporting rural hospitals, yet this is an instance where

CMS policy is doing the opposite. CMS has ample authority to make 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).

To protect the viability of rural hospitals, it is essential that CMS examine how its current rate-setting methodology can contribute to disproportionate disadvantages to rural hospitals. Additionally, should this examination reveal such systematic, negative impacts on rural hospitals, CMS should consider making payment methodology adjustments.

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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