Headquarters
7015 College Blvd.; Suite 150
Overland Park, KS 66211
Telephone: [816] 756.3140
FAX: [816] 756.3144

Government Affairs Office
50 F St., N.W. Suite 520
Washington, DC 20001
Telephone: [202] 639.0550
FAX: [816] 756.3144

NATIONAL RURAL HEALTH ASSOCIATION

June 21, 2021

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Medicare Program; Fiscal Year 2022 Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) Proposed Rule

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for fiscal year (FY) 2022. We appreciate CMS's continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health and health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We provide leadership on rural health issues through advocacy, communications, education, and research.

II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights

NRHA supports the repeal of the requirement for hospitals to report median payer-specific negotiated rates for inpatient services, by Medicare Severity-Diagnosis Related Group (MS-DRG), for Medicare Advantage organizations on the Medicare cost report. This requirement would force rural hospitals to undertake the extremely burdensome task of collecting and assembling data and disclose privately negotiated contract terms to the public. NRHA was concerned that this burden imposed on rural hospitals would not result in any useful data for CMS. Rural hospitals have little negotiating power with Medicare Advantage organizations, and typically contract for 100 percent of Medicare rates, offering no data that CMS could use to adjust MS-DRG weights.

III. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals, G. Application of the Rural Floor, Application of the State Frontier Floor, and Continuation of the Low Wage Index Hospital Policy, and Proposed Budget Neutrality Adjustment

NRHA recommends extending the hold-harmless wage index policy from last year regarding OMB Bulletin 18-04 to hold the FY 2022 wage index for those hospitals harmless from any reduction relative to their FY 2021 wage index. By continuing CMS's policy implemented from last year implementing another 5 percent cap on negative wage index changes, the policy is narrowed to a small subset of hospitals and limits any potential budget neutrality impact on other hospitals, including rural hospitals, who are still struggling to recover from COVID-19.

NRHA supports the continued efforts to improve payments for those in the bottom quartile of the wage index. We continue to urge CMS to hold harmless struggling rural and Indian Health Service providers whose wage indexes have previously been adjusted to better reflect costs. The continued effort by CMS to reexamine and adjust the wage index is appreciated. NRHA has an extended history, dating back to the start of our organization, of fighting the wage index inequalities harming rural providers seeking to care for rural Americans. Continuing the low wage index policy will create greater equity among providers and will significantly help the many struggling rural hospitals who provide care for a disproportionately high number of seniors.

V. Other Decisions and Changes to the IPPS for Operating System, J. Proposed Payment for Indirect and Direct Graduate Medical Education Costs (§§ 412.105 and 413.75 through 413.83), 2. Provisions of the Consolidated Appropriations Act 2021 (CAA)

About three in five Health Professional Shortage Areas (HPSA) are in rural communities. While 20 percent of the U.S. population lives in rural communities, only an estimated 10 percent of physicians practice in those communities. According to the most recent HRSA data, 15,361 additional physicians are needed to fully address workforce shortages in all HPSAs, and nearly 4,000 additional physicians are needed to fully address workforce shortages in rural HPSAs. Approximately 25 percent of the U.S. population lives in regions without sufficient access to primary care, dental and mental health care providers. Absent decisive federal action, these shortages will worsen. By 2030, the number of practicing rural physicians could be reduced by a quarter as aging physicians retire. The number of medical school graduates with rural backgrounds, those most likely to practice in rural areas, is decreasing: from 2002 to 2017, medical school matriculants from rural areas declined by 28 percent, even though the overall number of graduates increased by 30 percent.

NRHA proposes the following recommendations for Section 126 of the CAA, delineating allocation of the 1,000 additional GME slots. *(a. Distribution of Additional Residency Positions Under the Provisions of Section 126 of Division CC of the CAA.)*

Definition of a Qualifying Hospital: NRHA supports CMS's proposed criteria for hospital eligibility to apply for new GME slots. **In addition to provider-based facilities, non-provider-based facilities where a hospital may count training time for IME/DME purposes (such as critical access hospitals, rural health clinics, FQHCs, etc.) should be included.** This modification is needed to ensure that community-based settings, which often serve as primary training locations for family medicine, are included in the definition. Congress clearly intended to ensure that these training slots be allocated to hospitals and facilities that provide care to medically underserved populations. This expansion of eligible facilities, along with the 50 percent training requirement, will ensure residency positions obtained under this criterion are not used to primarily serve populations that do not face physician shortages.

Prioritization of Applications from Hospitals for Residency Programs that Serve Underserved Populations: **NRHA strongly agrees with the agency's goal of addressing existing health inequities and improving timely access to high-quality care for underserved populations. We**

believe that by including geographic HPSA, this proposal will help to address the maldistribution of physicians over time. Our organization again urges CMS to include non-provider-based settings in this definition. We agree that prioritizing geographic and population HPSAs and using HPSA scores would ensure residency slots are awarded to those programs serving high proportions of underserved patients.

CMS Proposed Alternative Approach for Prioritization of Applications: **NRHA strongly opposes CMS's proposal to prioritize providing all 200 slots in FY 2023 to states that meet all four criteria. The impact will be that only states with new medical schools or branch campuses would receive additional residency slots.** Since graduates of new medical schools are 40 percent less likely to become primary care physicians, we are concerned that CMS could inadvertently reduce the primary care pipeline and worsen physician shortages in rural and underserved areas by favoring states with new medical schools. Instead, we recommend CMS move forward with their original proposal to advance our shared goals of improving access to comprehensive care in rural and underserved parts of the country.

NRHA supports the majority of CMS's proposal for implementation of Section 127 of the CAA, focused on promoting rural hospital GME funding opportunity. (b*. Proposal for Implementation of Section 127 of the CAA, "Promoting Rural Hospital GME Funding Opportunity")*

There are several areas under this section of the proposed rule that we believe CMS did an excellent job implementing the statute, and we support them without reservation. These include:

- **CMS's suspension of the application of the rolling average to the establishment of new rural training track programs.** For new RTTs started in cost reporting periods beginning on or after October 1, 2022, the three- year rolling average will not apply until the five-year cap-setting period is completed. Specifically, residents would not be included in a hospital's three-year rolling average calculation during the cost reporting periods prior to the beginning of the applicable hospital's cost reporting period that coincides with or follows the start of the sixth program year of each rural track. This applies to both the urban and rural hospitals.
- **Proposal to allow for increases in both the urban AND rural caps (limitations on FTEs).** Prior to this proposal, based on CMS's reading of the statute, it would only allow increases in a rural cap for new programs. This proposal allows for changes to a rural cap. CMS proposes that each time an urban hospital and rural hospital establish a RTT program for the first time, even if the RTT program does not meet the newness criteria for Medicare payment purposes, both the urban and rural hospitals may receive a rural track FTE limitation. This would allow for an existing RTT to establish new sites of training (locations in rural areas) and adjust both the urban and rural hospitals' cap each time a new training site (RTT) is established. This applies for expansion of new sites for existing RTTs in cost reporting periods beginning on or after October 1, 2022.
- **Allowance to add new locations of training sites to amend the rural limitation on the urban hospital.** Specifically, CMS proposes that if an urban hospital with an existing RTT ("hub") adds an additional RTT ("spoke") to the existing urban core program of the same specialty, the urban and rural hospitals may receive adjustments to their rural track FTE limitation. (For ease of reference, CMS refers to the urban core hospital as the "hub" and the one or more RTTs as the "spokes" associated with that urban "hub.")
- **Removal of the separate accreditation requirement.** In keeping with the statute, the proposal removes this requirement. We support maintaining the requirement that programs within this category must have residents train in rural locations for greater than fifty percent of their time.

NRHA strongly recommends the following change is made to CMS's proposal for implementation of Section 127 of the CAA, focused on promoting rural hospital GME funding opportunities.

- **Restriction to not allow cap adjustments for existing "spokes."** CMS proposes the concept of a "hub and spoke" model where the hub is the urban teaching hospital, and the spoke is the rural training site(s). However, CMS is proposing to not allow an increase to an *existing* rural RTT "spoke." CMS states that to do so would render the RTT cap meaningless. This would exclude already existing rural training sites from expanding their caps, while new sites would be permitted to receive new caps and new funding. We believe there is nothing in Section 127 that precludes CMS from providing the opportunity to existing rural sites to adjust caps to allow for expansion. CMS would be overly and unnecessarily restrictive to not exercise its authority to permit cap adjustments for existing "spokes" and would be acting against Congressional intent. It will only hinder rural hospitals that have previously developed RTTs to potentially avail themselves of the new opportunity presented by Section 127. It is both expensive and difficult to open new sites of training. The difficulty in developing a rural infrastructure (faculty, staff, etc.) makes the expansion of existing sites as much, if not more, useful than adding new sites, and should be considered a viable option. **Therefore, NRHA strongly recommends that CMS exercise its authority to permit cap adjustments for existing "spoke" sites.**

NRHA supports the majority of CMS's proposal for implementation of Section 131 of the CAA, address adjustments of Low Per Resident Amounts and Low FTE Resident Caps for Certain Hospitals. (*c. Proposal for Implementation of Section 131 of the CAA, Addressing Adjustment of Low Per Resident Amounts (Direct GME) and Low FTE Resident Caps (Direct GME and IME) for Certain Hospitals.)*

We are concerned about hospitals, many of them rural, that have no immediate plans to become teaching hospitals, who have no cap, and that are unaware of any per resident amount (PRA). These do not fall under Category A or B as identified by CMS. Per resident amounts have not been proactively assigned to every hospital in the U.S., and under current regulations, a PRA of $0 is only discovered when a resident is first reported on a cost report and the required audit reveals a past incident of resident training for which the hospital claimed no cost. We request that CMS publish a list of eligible hospitals; if that is not possible, we request that CMS require its MACs to identify – as soon as possible – hospitals that would fit the criteria for a PRA reset and communicate that information to the hospitals who would be eligible if a PRA had been set.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care. If you would like additional information, please contact Josh Jorgensen at jjorgensen@nrharural.org, or 202-639-0550.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association