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June 17, 2019

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

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals

Dear Administrator Verma,

The National Rural Health Association (NRHA) is pleased to offer comments on the CMS proposed rule for the Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates; Proposed Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Promoting Interoperability Programs Proposed Requirements for Eligible Hospitals and Critical Access Hospitals. We appreciate your continued commitment to the needs of the 62 million Americans residing in rural areas and look forward to our continued collaboration to improve health care access and quality 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 work to improve rural America's health needs through government advocacy, communications, education and research.

NRHA strongly supports changes to improve payments for those in the bottom quartile of the wage index. This correction of a long-standing inequity will create greater parity in payments for many financially distraught rural providers. We also urge CMS to hold harmless struggling rural and Indian Health Service providers whose wage index has previously been adjusted to better reflect costs and who may be disadvantaged due to this change. The focus and willingness of CMS to reexamine and adjust the wage index is long

overdue and appreciated. NRHA has an extended history, dating back to the start of our organization, of fighting the wage index inequities harming rural providers seeking to care for rural Americans. This strong policy improvement 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. Many rural hospitals in low wage index areas struggle on a daily basis to remain solvent following a plethora of payment cuts and policy changes that have led to the current astounding rate of rural hospital closures. As of last year, 46 percent of rural hospitals were operating at a loss, up from 40 percent just two years before with preliminary data showing the trend continues. Since 2010, 107 rural hospitals have closed with two occurring within a week of this writing.

Rural communities are greatly affected by the maldistribution of healthcare professionals. Indeed, the Robert Wood Johnson Foundation found that maldistribution was a much larger problem than an absolute shortage of primary care providers. One aspect of this maldistribution is the fact that urban facilities offer better salaries and benefits, plus the additional benefits of greater peer support from a larger workforce. Economic forces would indicate that paying higher, not the lower rates already provided for under the wage index, is the appropriate response to workforce maldistribution. Basic economic principles indicate the rural wage index should exceed that of the urban areas without shortages, instead of a low index based on the cost of living. Indeed the very existence of the wage index is self-perpetuating in that a rural community is provided fewer resources and is thus unable to afford higher wages resulting in either hiring only those that can and will accept lower wages, while also not filling other positions that if filled would potentially lift their wage index. In reality, professional markets do not drop abruptly at the county line, instead they change over areas with some professionals traveling from market to market for a variety of reasons including wages. It is expected that some rural areas would share professional marketplaces with neighboring communities that may be larger, while still retaining their rural nature. NRHA urges CMS to reconsider the wage index as a tool to reduce maldistribution of health care providers instead of just attempting to focus on the spending power of that money.

However, we need to ensure that in those rural places where the wage index is has already recognized the difficulty in recruiting and retaining a health care workforce are not penalized under this change. NRHA supports a hold harmless for rural providers that would be negatively impacted by this change to ensure access in these rural areas is not eroded by this policy.

NRHA strongly supports the changes to GME to allow for the inclusion of residents training in CAHs. Rural hospitals struggle to recruit and retain a health care workforce sufficient to meet the needs of the rural communities they serve. One important tool for recruiting and retaining this workforce is training in a rural area. This has been shown again and again to increase not only recruiting providers into these underserved areas, but also to recruit the right workforce that is likely to remain long term and become a member of the community they serve. One important tool for such training is to ensure appropriate reimbursements for this essential training. By extending the “non-provider setting” to include residents training at a CAH in the full-time equivalent medical resident in the program for the Medicare GME payments will allow for greater rural training of future physicians and thus a larger workforce with rural experience that may choose to live and work in rural America.

NRHA appreciates changing the rural reclassification application process to allow for electronic submission.

NRHA supports the clarification related to the eligibility for cost-based ambulance services by a CAH. This clarification resolves a problem that exists in which an ambulance provider or supplier is located within 35 miles of the CAH, but the ambulance is not legally authorized to provide services to or from the CAH. Since CAH owned and operated ambulance services are not eligible for cost-based payments if there is another ambulance provider or supplier within 35 miles of the CAH the previous interpretation created a situation counter to the congressional intent where no ambulance service was available yet the CAH protections did not extend to the ambulance service. NRHA appreciates this common-sense clarification and applauds CMS for listening to rural providers. This change will potentially increase ambulance access in rural and frontier areas.

NRHA continues to be concerned about the trend that budget neutral adjustments to reconcile MS-DRG changes are disproportionately disadvantaging rural hospitals. While each of the annual updates have been seemingly small reductions for rural providers, for example in FY2019 CMS estimates the adjustment will cause a 0.3 percent payment reduction for rural hospitals while resulting in a positive update of 0.1 percent for urban providers, the overall additive impacts are growing for rural hospitals. For SCHs, as an example, this amounts to about 2.5 percent cut over the past 8 years, contributing to growing disparities in the gap between rural and urban hospitals. CMS has been clear about supporting rural hospitals, but unfortunately, this alarming trend has continued. While we recognize that the case mix at rural hospitals coupled with the weighting changes is the ultimate cause of this disparity, the basic case mix differential is well known and therefore the impact is predictable. We believe this should be examined using a rural lens to identify the unintended negative impacts on vulnerable rural communities and patients, per the CMS Rural Health Strategy. Under Section 1886(d)(5)(I)(i) of the Social Security Act, which allows “other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate.” This authority has been previously used by CMS when the MS-DRGs were implemented and has potential to remedy the disadvantages for rural hospitals. This flexibility could be utilized to reevaluate the size of the documentation and coding cuts of rural hospitals to recalibrate overall reimbursement to allow small rural hospitals to remain open and serving their communities.

NRHA urges CMS to expand the availability of cost-based reimbursement for ambulance services serving CAHs where patient transfer is required based on the CAH Conditions of Participation. CAHs are uniquely required to transfer certain patients to receive care at other facilities. In many rural areas, even those that are otherwise served by an ambulance service, the CAH often struggles to find medical transport for facility to facility transfers. Rural ambulance services are often staffed by limited number of volunteers and are unable to provide the type of urgently needed facility to facility transfer because of limited equipment and staffing. Expansion of the CAH cost-based reimbursement to this transportation, required as a part of the COP is consistent with the statute and CMS’s commitment to ensuring rural Americans have access to care.

NRHA continues to support the Low-Volume Adjustment changes included as a result of the Bipartisan Budget Deal of 2018.

NRHA supports the changes to the Disproportionate Share Payments (DSH) to ensure payments are going to rural hospitals that are seeing an increasing amount of bad debt and charity care. Rural hospitals have been seeing an increasing amount of bad debt since 2010.

NRHA appreciates CMS's recognition that bad debt and charity care need to be considered together if using the S-10 data to ensure hospitals actual level of charity care is more accurately assessed. The result of this appropriate review is that rural hospitals, especially those small rural hospitals serving vulnerable patient populations will see an increased share the DSH payments. We appreciate the detailed analysis recognizing the disproportionate impact of bad debt and charity care on small and rural hospitals. With 46% of rural hospitals operating at a loss and 107 hospitals already closed since 2010, each change to appropriately reimburse hospitals for the care they are providing to vulnerable patients is an essential piece of ensuring access to care in rural America.

NRHA supports the inclusion of sociodemographic risk in the Hospital Readmission Reduction Program (HRRP), however, we continue to urge adoption of a more suitable measure of sociodemographic risk since Medicaid rate is not a sufficient proxy. It is essential that providers not be penalized for factors outside of their control, especially when providing care for vulnerable patient populations. Such penalties will serve to further erode the rural health care safety net already feeling the strain from repeated Medicare reimbursement cuts that MedPAC continues to report make reimbursement rates on average below the cost of providing care. Rural patients are on average older, sicker, and poorer than their urban counterparts with higher rates of chronic disease and higher rates of lifestyle choices detrimental to health, such as tobacco use and opioid addiction. Numerous studies have demonstrated that rural providers deliver excellent high-quality care, however, these patient factors have been well documented to impact patient outcomes even when the care provided exceeds standards of care. It is essential that providers that are willing to provide care to this type of vulnerable patient population not be penalized for outcomes that are outside of their control and that do not reflect the care provided.

While we recognize that dual eligibility is an easy metric to identify and does provide some useful information about the patient population it is not itself sufficient to identify sociodemographic risk. A 2017 Center for Disease Control (CDC) study found that “[t]he death rate gap between urban and rural America is getting wider” as a result of the fact that the rate of the five leading causes of death- heart disease, cancer, unintentional injury, chronic respiratory disease, and stroke – are all higher amount rural patients. Additionally, risky lifestyles, environmental factors, and mental health issues leading to suicides, negatively impact rural life expectancy. A plethora of other studies demonstrate similar indications of sociodemographic risk. These factors are not fully accounted for by the disparity between rural and urban Medicaid rates (21% rural vs. 16% urban).

NRHA supports the goal of interoperability and data sharing with patients. NRHA supports the proposed 90-day reporting period for attestation for the Promoting Interoperability Programs, however we continue to urge the burden be on the software companies not the small rural hospitals since only the software companies have the power to comply with these regulations. Rural hospitals have attempted to make prudent choices in attaining EHR products. However, many have found themselves needing to purchase new products when the vendor selected to not upgrade the product, leaving some hospitals to have to take the time and expense of setting up and training staff on multiple software programs. Further complicating the use and upgrades required, many rural communities do not have a sufficient IT workforce. Therefore, NRHA applauds the continued flexibility provided while continuing to move towards the laudable goal of interoperability and urges CMS to consider

additional hardship exemptions for small rural providers that find themselves unable to upgrade due to vendor decisions.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Alan Morgan
Chief Executive Officer
National Rural Health Association