

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1786-P; 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.

Submitted electronically via regulations.gov.

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 Hospital Outpatient Prospective Payment System for calendar year (CY) 2024. We appreciate CMS' 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 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, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

II. Proposed Updates Affecting OPPS Payments.

B. Proposed Conversion Factor Update.

NRHA thanks CMS for its 2.8% payment update relative to CY 2023. **We are pleased that rural hospitals across the board will see an estimated 4.4% increase.** However, NRHA continues to be concerned about the discrepancy between Medicare payment rates and actual inflation. Compounding CMS' underpayment, rural hospitals and health systems also face labor and supply cost pressures and workforce shortages. The projections that CMS uses for updating payment rates have recently been lower than actual inflation because historical data is used. Using historical inflation data leads to inadequate payment updates. In general, hospital inflation lags behind economy-wide inflation, so the 9 – 10% inflation rates that the country saw last summer are likely now affecting hospitals.

It is critical that CMS explores how it can accurately pay rural hospitals by accounting for inflation and historical underpayment. Rural hospitals continue to struggle coming out of the COVID-19 pandemic, especially as federal relief funds that largely stalled hospital closures have run out.¹ 153 rural hospitals have closed since 2010, the majority of which were PPS hospitals.² In 2023 alone 12 hospitals have closed³ making this year is on pace to match or surpass 2020 as the year with the most hospital closures at 19.⁴ Additionally, estimates show that more than 450 additional hospitals are vulnerable to closure.⁵

Closures are only one measure of hospital financial instability. Nearly 45% of rural hospitals are operating in the red and the overall median rural hospital operating margin is 1.8%.⁶ When hospitals are operating with low or negative margins they often cease less profitable yet important service lines, most notably obstetrics or chemotherapy, leaving rural beneficiaries without a local point of access to care.⁷ **We urge CMS to finalize higher payment rates for CY 2024 to help sustain access to care for Medicare beneficiaries in rural communities.**

Further, **NRHA supports CMS' proposed continuation of the 7.1% payment adjustment for rural sole community hospitals (SCHs).** We ask CMS to finalize this policy as proposed. We also ask that CMS consider extending this payment increase to Medicare Dependent Hospitals (MDHs), which by definition are rural hospitals. CMS has the authority to make this change without legislation through a study of costs incurred by rural hospitals compared to urban hospitals. CMS should perform another study to look at the costs MDH incur and make an adjustment similar to what SCHs receive.

VII. Proposed OPPS Payment for Hospital Outpatient Visits.

In last year's OPPS rulemaking cycle, CMS finalized a policy to exempt provider-based departments of rural SCHs from site-neutral payment policies. NRHA thanks CMS for proposing to continue this policy. **We also ask that CMS consider exempting small rural hospitals with less than 100 beds, MDHs, and Low-Volume Hospitals in a future rulemaking cycle.** The same reasoning that led CMS to propose to exempt SCHs also applies to all small rural hospitals. Factors other than the payment differential can be attributed to the volume of services in provider-based clinics of rural hospitals.

¹ Michael Topchik, et al., *Rural Health Safety Net Under Renewed Pressure as Pandemic Fades*, The Chartis Group (2023), 4 <https://www.chartis.com/insights/rural-health-safety-net-under-renewed-pressure-pandemic-fades>.

² Rural Hospital Closures, N.C. Rural Health Research Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill <https://www.shepscenter.unc.edu/programs/projects/rural-health/rural-hospital-closures/> (this number includes hospitals that converted to another hospital type, such as the Rural Emergency Hospital designation).

³ *Id.*

⁴ Topchik, et al., *supra* note 1 at 1.

⁵ *Id.*

⁶ *Id.* at 3.

⁷ *Id.* at 11.

VIII. Payment for Partial Hospitalization and Intensive Outpatient Services.

B. Intensive Outpatient Program Services.

CMS is proposing to implement the new Intensive Outpatient Program (IOP) benefit that Congress created in the Consolidated Appropriations Act (CAA) of 2023.⁸ NRHA commends CMS for its work implementing this program as it will serve as an important gap filler for the behavioral health needs of rural beneficiaries. We are pleased to see that rural health clinics (RHCs), critical access hospitals (CAHs), and federally qualified health centers (FQHCs) are eligible to furnish IOP services, hopefully increasing rural uptake of this program. Unfortunately, the similar, more intensive program, the Partial Hospitalization Program (PHP), has not seen widespread rural use. Only about 11% of nonmetropolitan hospitals offer PHP compared to almost 40% of all urban hospitals.⁹

2. IOP Scope of Benefits.

NRHA thanks CMS for including IOP services in the definition of medical and other health services provided incident to physicians' services at hospital and critical access hospitals (CAHs). NRHA hopes that IOP services at a CAH will encourage rural participation in the new program.

We ask that CMS clarify that the new IOP benefit can function alongside existing outpatient psychiatric services. Beneficiaries should still be able to receive any of the services under the IOP benefit individually and providers should be able to bill for each service individually. IOP is a distinct and organized ambulatory treatment program that may not supplant other behavioral health services. **CMS should clarify that the IOP benefit does not preclude beneficiaries from receiving other services, including remote mental health services.**

3. IOP Certification and Plan of Care Requirements.

CMS is soliciting comments on whether it is appropriate to include peer support services in IOP and PHP. **NRHA supports including peer services in IOP and PHP.** Rural areas are facing a dearth of behavioral health practitioners and oftentimes rely upon professionals with less intensive education and training requirements, like peer support specialists. Peer support specialists help to fill in unmet service gaps in behavioral health, such as filling out paperwork and finding community resources, freeing up other providers to practice at the top of their training.¹⁰ This is crucial in rural areas that lack behavioral health providers because peer support specialists may take some of the workload off of other practitioners. Peer support specialists also bring lived experience to their work, which can help them address the unique needs of rural beneficiaries with behavioral health diagnoses. Peer support specialists could be treated similarly to community health workers in CMS' proposed community health integration services.¹¹ Peer support specialists could work under the general supervision of a billing practitioner.

⁸ Consolidated Appropriations Act of 2023, H.R. 2617, 117th Cong. § 4124(b) (2022).

⁹ Rural Health Research Gateway, *Opioid Use Disorder and Treatment: Rural-Urban Comparisons*, Feb. 2022, <https://www.ruralhealthresearch.org/assets/4628-20490/opioid-use-disorder-treatment-recap.pdf>.

¹⁰ Allee Mead, *Peer Support Specialists Care for and Connect Rural Behavioral Health Clients*, THE RURAL MONITOR (Feb. 6, 2019), <https://www.ruralhealthinfo.org/rural-monitor/peer-support-specialists>.

¹¹ 88 Fed. Reg. 52,326.

D. Proposed Payment Rate Methodology for PHP and IOP.

The CAA mandated that RHCs be paid the same as hospital outpatient departments for IOP services. Costs associated with IOP services cannot be used to determine the payment for RHC services under the all-inclusive rates. **We support CMS' calculation of the IOP payment methodology, specifically the hospital and RHC rates.** We understand that the statutory language is clear on RHC payment being "equal to the amount that would have been paid under this title for such services had such services been covered OPD services furnished by a hospital." However, **we ask that CMS apply the hospital-based IOP rate for 4-service days to RHCs to account for any variations in the cost of furnishing these services in RHCs compared to other settings and geographic areas.**

In addition, we suggest that upon implementation of the IOP, CMS monitor the costs associated with providing the benefit that RHCs incur compared to other settings. We predict that freestanding RHCs specifically may face higher costs than hospitals and if RHC payment is not adequate, they may opt to not furnish IOP services. Provider-based RHCs may not to offer IOP services if the hospital chooses to because of the cost.

G. Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Programs (OTPs).

CMS proposes to provide coverage of IOP services furnished at OTPs. NRHA thanks CMS for this proposal as it goes beyond what the CAA, 2023, required of CMS when implementing the IOP program. We agree with CMS' goal of increasing access to OUD treatment for underserved populations.

X. Proposed Nonrecurring Policy Changes.

A. Supervision by Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR) Services Furnished to Hospital Outpatients.

NRHA thanks CMS for its policies surrounding non-physician practitioners (NPPs) and CR, ICR, and PR services. NPPs are integral to rural health care delivery and should be used to the fullest extent of their license and training. Additionally, we appreciate the extension to allow virtual presence via telehealth to meet the definition of direct supervision through 2024.

B. Payment for Intensive Cardiac Rehabilitation Services (ICR) Provided by an Off-Campus, Non-Excepted Provider Based Department (PBD) of a Hospital.

Site neutral payment policies are particularly harmful to rural providers. We applauded CMS' decision to exempt off-campus provider-based departments (PBDs) of rural sole community hospitals from the site neutral payment policy in last year's final OPSS rule. NRHA is similarly pleased to see that CMS will pay the full OPSS rate for ICR services at non-exempted off-campus PBDs.

XVIII. Proposed Updates to Requirements for Hospitals To Make Public a List of Their Standard Charges.

B. Proposal To Modify the Requirements for Making Public Hospital Standard Charges at 45 CFR 180.50.

3. Proposal To Improve the Standardization of Hospital Machine Readable File (MRF) Formats and Data Elements.

NRHA has significant concerns about rural hospitals' capacity to meet hospital price transparency (HPT) requirements. We have consistently expressed¹² that rural hospitals will struggle to dedicate staff and resources to complying with the HPT regulations and potential civil monetary penalties. **NRHA opposes further additions to HPT regulations that will be overly burdensome for rural hospitals.**

NRHA does not support adopting most new required data elements for machine-readable files (MRFs). In particular, we believe that the following proposed data elements will pose another administrative burden on rural hospitals:

- The contracting method they used to establish the payer-specific negotiated charge.
- Whether the payer-specific standard charge listed should be interpreted by the user as a dollar amount, percentage, or, if the standard charge is based on an algorithm.
- The "expected allowed amount."
- Indicating the drug unit and type of measurement as separate data elements.
- Recasting the required description of the item or service and whether the standard charge is for an item or service as a separate data element.
- Adding any relevant modifiers to codes needed to describe the established standard charge and the code types.

NRHA does support including the following new data elements in its MRF:

- The hospital name, license, location, and address to which the standard charge information applies.
- The file version and date of the most recent update.
- Allowing hospitals to indicate plans as categories (such as "all PPO plans") so that hospitals do not have to research and insert repetitious standard charge information for each plan.

We believe that these proposed elements strike a balance between hospital burden and transparency for patients.

CMS is also proposing to mandate use of a CMS-developed template for hospitals' MRFs. In theory, a standardized template would remove administrative burden from hospitals, particularly for urban or well-resourced hospitals. Rural hospitals would likely see little benefit from using a template because they still need the staff and resources to use the template and understand how to meet the associated requirements. **NRHA stresses that rural hospitals need technical assistance and**

¹² [https://www.ruralhealth.us/getmedia/55fe50f1-ecdf-42fa-84c6-8d45b171d11f/NRHA-Comments-on-Requirements-Related-to-Surprise-Billing-\(Part-I\).aspx](https://www.ruralhealth.us/getmedia/55fe50f1-ecdf-42fa-84c6-8d45b171d11f/NRHA-Comments-on-Requirements-Related-to-Surprise-Billing-(Part-I).aspx) and <https://www.ruralhealth.us/getmedia/5765f1a7-e650-4d14-901c-0e4d8842b8a1/NRHA-Comments-on-Medicare-CY-2022-Hospital-Outpatient-Prospective-Payment-and-Ambulatory-Surgical-Center-Payment-Systems.aspx>

support to comply, not just standardized templates. Additionally, for rural hospitals that are currently in compliance with their MRF, using a new template will create more work. The hospital will have to redo their MRF using the CMS template despite having one in place already.

NRHA asks that CMS does not finalize its proposal to require hospitals to use a CMS standardized template for their MRFs. We appreciate CMS' proposal to make three layouts available for the standardized templates so that they are more accessible to hospitals with varying levels of technical expertise. However, using a template should remain optional as it is now. We disagree that now is the time to be more prescriptive in data formatting requirements, particularly for rural hospitals that are continually struggling to keep up with HPT regulations. **Alternatively, if CMS moves forward with the new template and data elements, NRHA urges CMS to extend the grace period from 60 days to 120 days after the effective date of this rule for small rural hospitals and CAHs.** Nothing in the HPT statute prohibits this grace period and rural hospitals would benefit from additional time to comply.

XVI. Proposed Requirements for the Rural Emergency Hospital Quality Reporting (REHQR) Program.

B. REHQR Program Quality Measures.

1. Considerations in the Selection of REHQR Quality Measures.

NRHA thanks CMS for its thoughtful consideration of quality measures for REHs. We agree that it is critical to balance patient safety and the capacity of small facilities to take on reporting burdens. CMS' approach to analyzing the measures that REH- eligible facilities have successfully reported on will likely ensure that REHs are able to succeed in the REHQR Program.

5. Proposed New Measures for the REHQR Program Measure Set.

We agree that emergency department (ED) care will be a focus of REH services, thus measures assessing quality care in the ED are important. NRHA understands CMS' dedication to improving hospital overcrowding as it affects wait times and patient outcomes. NRHA recognizes the utility of the Median Time from ED Arrival to ED Departure for Discharged ED Patients measure (ED throughput measure), but we argue that it includes potentially problematic stratifications. In particular, NRHA is concerned about the calculation included for transfer patients.

The Measures Application Partnership (MAP) stated that changes in wait times may not directly influence mortality or patient outcomes and expressed concerns that transfer times may be impacted by factors outside of a facility's control, like weather or transport safety issues. Further, the Rural Health Advisory Group maintained the same concerns. MAP did not support including this measure in the REHQR Program and we concur with this assessment.

NRHA disagrees with CMS' argument for including the ED throughput measure against MAP's recommendation. CMS explains that, despite variables such as weather or other transport issues, "[CMS believes] that some factors such as building transfer relationships and process improvements can be addressed by hospitals to improve ED wait times."¹³ This does not account for the availability of emergency transport services and other unique rural characteristics (geographic spread, isolation,

¹³ 88 Fed. Reg. 49,834.

etc.). We do not believe that reporting on this measure would “build transfer relationships” where the transfer infrastructure does not exist.

NRHA suggests that if CMS finalizes inclusion of the ED throughput measure it does not publicly report on the transfer time stratum. Currently, hospitals in the Outpatient Quality Reporting Program do not publicly report on the transfer measure, but only report on the reported measure (all patients excluding psychiatric and mental health) and psychiatric/mental health patients strata. CMS should keep this consistent in the REHQR Program.

D. Proposal To Pay IHS and Tribal Hospitals That Convert to an REH Under the AIR.

We are supportive of IHS and tribal hospitals converting to an REH. In our comment on last year’s Conditions of Participation for Rural Emergency Hospitals proposed rule, we asked that CMS allow IHS facilities to convert to REH.¹⁴ In order to make conversion a meaningful opportunity for these facilities, **NRHA supports CMS’ proposal to allow IHS and tribal hospitals to continue to be paid under their all-inclusive rate for hospital outpatient services** rather than the REH payment methodology.

Thank you again for the opportunity to respond to this proposed rule and for consideration of our comment. We look forward to continuing our work together to ensure access to quality care for rural beneficiaries. If you have any questions, please contact NRHA’s Regulatory Affairs Manager, Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

¹⁴ <https://www.ruralhealth.us/getattachment/Advocate/Executive-Branch/NRHA-REH-CoP-Comment-FINAL-8-29-22.pdf.aspx?lang=en-US>.