

September 11, 2022

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

RE: CMS-1793-P; Medicare Program; Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018–2022.

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 to remedy the 340B-acquired drug payment policy in place during calendar years (CYs) 2018 – 2022. 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. Proposal To Remedy Payment Adjustment for 340B-Acquired Drugs From CY 2018 Through September 27th of CY 2022.

B. Proposed Remedy.

1. Proposed Methodology for Calculating and Process for Remitting Remedy Payments to Affected 340B Covered Entity Hospitals for 340B Acquired Drugs Furnished and Paid Adjusted Amounts Under the OPSS in CY 2018 Through September 27th of CY 2022.

NRHA thanks CMS for its consideration of the potential remedies discussed in subsection A. *Remedy Options Considered By CMS*. **We appreciate the decision to provide hospitals that were impacted by the unlawful policy with one-time lump sum payments. Additionally, we agree with CMS' calculation of the amounts owed to affected hospitals.** The difference between what hospitals should have been paid (i.e., under an average sales price [ASP] +6% policy) and what hospitals were actually paid (ASP -22.5% policy) from CY 2018 to September 27, 2022, will make rural hospitals whole.

2. OPSS Non-Drug Item and Service Payments From CY 2018 Through CY 2022.

NRHA is deeply concerned with CMS' proposal to prospectively adjust payments downward for all OPSS hospitals. **We urge CMS to exclude rural hospitals from its proposal to adjust the**

conversion factor by -0.5% for the next 16 years. From the outset, CMS acknowledged that rural hospitals are in a more vulnerable financial position by exempting rural sole community hospitals (SCHs) from the -22.5% payment policy. CMS must again acknowledge rural hospital vulnerability and provide **all** rural hospitals with relief from the proposed negative payment adjustment. NRHA appreciates that CMS calls out rural hospitals in the proposed rule once by stating that the 0.5% decrease spread out over a number of years will not be “overly financially burdensome on impacted entities, especially those in rural communities.”¹ However, **NRHA strongly disagrees with this assessment and does not believe that CMS accurately evaluated the impact on rural hospitals.**

Rural safety net hospitals are not in a position to receive cuts to Medicare reimbursement. Since 2010, 153 rural hospitals have closed, the majority of which were PPS hospitals.² Estimates show that more than 450 additional hospitals are vulnerable to closure.³ In 2023 alone 12 hospitals have closed, making this year on pace to surpass 2020 as the year with the most hospital closures at 19. Nearly 45% of rural hospitals are operating in the red and the overall median rural hospital operating margin is 1.8%.⁴ **Any additional payment cuts are a threat to a rural hospital's ability to remain open.** Losing a hospital is devastating to a rural community as beneficiaries no longer have a local point of access to care.

Vulnerable rural hospitals particularly are susceptible to closure if they are made to pay back the amount that they received in increased reimbursement. Increased reimbursement rates were distributed during the COVID-19 pandemic when rural hospitals needed all additional resources available to stay afloat and continue providing care to rural patients during a challenging time. Most, if not all, rural hospitals likely spent any funds that they received while the policy was in place.

Rural hospitals are uniquely situated to feel the payment cut more deeply than other hospitals because of their reliance on public payers, low volumes, and existing policies that reduce payment. NRHA urges CMS to reevaluate how the payment adjustment will affect rural hospitals. In isolation, the prospective payment adjustment may seem small as it is spread over approximately 16 years. The reality for rural hospitals, however, is that this cut is poised to reduce what little revenue a rural hospital may bring in.

In general, rural hospitals have higher Medicare and Medicaid⁵ volumes than urban hospitals. Thus, rural hospitals feel the effects of low Medicaid reimbursement and inadequate Medicare payment updates more acutely than urban hospitals. More reliance on public payers coupled with lower volumes means that rural hospitals do not see enough revenue to cover the cost of providing many services. Ultimately, many rural hospitals lose money when serving Medicare beneficiaries. CMS has continually finalized annual hospital payment updates that do not account for the reality of inflation,

¹ 88 Fed. Reg. 44087.

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 or otherwise ceased inpatient services).

³ Topchik, *supra* note 1.

⁴ *Id.* at 3.

⁵ Timothy McBride, et al., *An Insurance Profile of Rural America: Chartbook*, RURAL POLICY RESEARCH INSTITUTE, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH (Oct. 2022), 4, <https://www.shepscenter.unc.edu/download/25553/>.

workforce shortages, labor and supply chain pressures, and other costs. A downward adjustment on top of low reimbursement will devastate many rural hospitals.

For example, an NRHA member hospital noted that they typically lose around \$3 million per year on Medicare outpatient services, even during the period in which they received the additional reimbursement under the previous policy. This hospital estimates that they will lose around \$3.5 million in Medicare payments as a result of CMS' proposal. Another NRHA member notes that only two PPS hospitals in the state will receive lump sum payments and thus will see a positive net impact of such payments combined with the estimated payment reductions. However, the remaining PPS hospitals in this state are projected to experience more than \$64 million in payment reductions combined over the proposed 16-year period.

Further, since July 2022, rural hospitals have been grappling with 2% Medicare sequestration cuts on top of already inadequate Medicare reimbursement rates for low-volume facilities. Sequestration results in PPS hospitals receiving a 2% decrease in reimbursement for each Medicare payment received. Estimates show that the first year of sequestration likely cost rural hospitals \$500 million and 9,000 jobs.⁶ Sequestration will be in effect through 2031. **Again, CMS' proposal cannot be viewed in isolation. Other payment policies, and the reality of operating a rural hospital in the post-pandemic world, make CMS' proposal untenable for rural hospitals. CMS must consider carving rural hospitals out of the proposed downward adjustment.**

NRHA understands that the payment adjustment must reflect an offset to the lump sum payments made to hospitals. As such, if rural hospitals cannot be carved out, **NRHA urges CMS to monitor the impacts of decreased OPPS payments on rural hospitals to ensure that beneficiary access to care is not threatened by this proposed policy.**

Thank you again for the opportunity to provide feedback on the proposed rule and for consideration of our comments. We look forward to continuing our work together to ensure our mutual goal of improving quality and access to care for rural residents. If you would like additional information, please contact NRHA's Regulatory Affairs Manager, Alexa McKinley, at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

⁶ Topchik, *supra* note 1 at 4.