

June 9, 2023

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

RE: CMS-1785-P; Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

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 Inpatient Prospective Payment System (IPPS) for Acute Care Hospitals and Long-Term Care Hospitals (LTCH) for fiscal year (FY) 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, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

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

C. Proposed Changes to Specific MS- DRG Classifications.

12.c. Proposed Changes to Severity Levels.

NRHA supports CMS' proposal to change homelessness from non-complication or non-comorbidity to complication or comorbidity. This proposed severity level change will increase payments to rural hospitals that care for beneficiaries experiencing homelessness. The proposed severity level better reflects the increased resource utilization associated with caring for homeless individuals. NRHA also supports CMS' proposal to change the severity level for all three codes describing homelessness, including sheltered and unsheltered. Rural residents are more likely to

experience sheltered homelessness compared to their urban counterparts and are more likely to live in vehicles or temporarily with friends or relatives.¹

III. Proposed Changes to the Hospital Wage Index for Acute Care Hospitals.

G. Application of the Rural Floor, Application of the Imputed Floor, Application of the State Frontier Floor, Continuation of Low-Wage Index Policy, and Permanent Cap on Wage Index Decreases.

1.a. Treatment of Hospitals Reclassified as Rural Under § 412.103 for the Rural Wage Index and Rural Floor Calculation.

Pursuant to several courts' interpretations of § 1886(d)(8)(E) of the Social Security Act, which allows urban hospitals to reclassify as rural, CMS is proposing to include reclassified hospitals in states' rural wage index calculation. **NRHA supports CMS' proposal insofar as it does not negatively impact rural hospitals' wage index adjustments.** Based on the wage index tables put forth by CMS, we believe that this will likely boost most states' rural wage index.

4. Proposed Continuation of the Low Wage Index Hospital Policy and Budget Neutrality Adjustment.

NRHA supports continuing the low wage index for rural hospitals that have a wage index value below the 25th percentile. We understand and concur with CMS' position that there is currently insufficient data to support modifying or discontinuing the policy and support continuation of the current policy to allow further data collection.

Currently, the legal basis for the low wage index policy is being challenged in two federal appeals courts. NRHA recognizes that the policy may not be extended in the final rule depending upon the courts' decisions. However, if the courts find in favor of CMS and the Department of Health and Human Services (HHS), **NRHA asks that CMS continue the policy long enough to evaluate the impact on rural hospitals in a post-COVID-19 landscape.** The data that CMS will accumulate over the next few years may be inaccurate or otherwise misleading because of the effects of the pandemic on workforce and wages. For example, CMS notes that the FY 2023 wage index uses data from 2019 cost reports which do not account for the increases in salaries during and following the pandemic. NRHA urges CMS to continue the low wage index policy for at least through FY 2030 in order to collect wage data outside of the public health emergency (PHE).

I. Proposed Revisions to the Wage Index Based on Hospital Redesignations and Reclassifications.

3. Redesignations Under Section 1886(d)(8)(B) of the Act (Lugar Status Determinations).

Lugar Status is a beneficial wage index redesignation for certain rural hospitals and counties. A county with Lugar Status enables hospitals in the county to receive wage index adjustments that better reflect the labor costs in the area. For wage index purposes, hospitals in Lugar counties are considered urban because of commuting patterns from rural areas into neighboring urban counties. NRHA is supportive of Lugar Status and its benefits for rural hospitals.

However, **NRHA members have raised statutory interpretation concerns regarding Lugar Status and unrelated Medicare medical education programs:** Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME). Lugar status has no direct bearing on the DGME and

¹ National Advisory Committee on Rural Health and Human Services, *Homelessness in Rural America* (July 2014), <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/2014-homelessness.pdf>.

IME programs, however CMS is incorrectly tying together the two subsections regarding these programs and subsequently harming rural medical education.

IME payments are based on the ratio of resident physicians to the number of beds in a hospital, with a limit on how many residents are reimbursed. Rural hospitals are granted an exemption from limitations and may start new residency training programs. CMS has put forth an interpretation of the Lugar statute, contained in the Social Security Act (SSA), which considers hospitals in Lugar counties urban for IME purposes because of the reference to “this subsection.”² CMS maintains that “this subsection” refers to § 1886(d) of the SSA (or 42 U.S.C. § 1395ww(d)) and therefore a Lugar hospital is considered urban under all provisions of subsection (d), including IME.

NRHA argues that this interpretation is incorrect. The subsection governing IME, § 1886(d)(5)(B), cross-references the section governing DGME at § 1886(h) where a non-Lugar definition of rural is applied. Accordingly, the IME rules in the SSA incorporate the DGME subsection by reference, including the standard, non-Lugar, definition of rural. Further, CMS’ interpretation is inconsistent with its historical treatment of Lugar hospitals. CMS has treated Lugar hospitals as rural for under other provisions in § 1886(d), such as for Medicare Geographic Classification Review Board reclassification, governed by § 1886(d)(10).

Accordingly, NRHA asks that CMS reconsider its interpretation of the Lugar statute in the future. IME cap adjustments allow rural hospitals to start new residency programs, but the exemption only applies to rural, not urban, hospitals. Classifying Lugar hospitals as urban results in lower IME payments for these rural hospitals and will stifle the growth of much needed rural residency programs. NRHA urges CMS to rethink its interpretation of the statute to support much needed rural residency training.

IV. Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2024 (§ 412.106).

E. Uncompensated Care Payments (UCP).

In calculating the uncompensated care payment, CMS uses projections on the percent of uninsured individuals nationwide from the Office of the Actuary (OACT). OACT projects that for calendar year (CY) 2024 the rate of uninsured individuals will be 9.2%. This projection was 9.3% for CY 2023.

NRHA disagrees with this percentage and urges CMS to consider any new data that becomes available before the final rule is released. Accurate projections of uninsurance and Medicaid enrollment is important for accurate DSH and UCP payments to rural hospitals because about one quarter of all rural adults are enrolled in Medicaid and rural areas see higher average uninsurance rates compared to urban.³

² 42 U.S.C. § 1395ww(d)(8)(B)(i) (2018) (“*For purposes of this subsection, the Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if the rural county would otherwise be considered part of an urban area*”) (emphasis added).

³ Medicaid and CHIP Payment and Access Commission (MACPAC), *Medicaid and Rural Health*, April 2021, 1, <https://www.macpac.gov/wp-content/uploads/2021/04/Medicaid-and-Rural-Health.pdf>; 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/>.

Due to the expiration of the Medicaid continuous enrollment requirement, we anticipate that the uninsurance rate will be higher than 9.3% for CY 2024. The continuous enrollment requirement was in place until April 1, 2023, meaning that no Medicaid enrollees could lose coverage for the first three months of the year. Additionally, most states are not beginning to terminate coverage until June 2023, or halfway through this year.⁴ However, by 2024 all states will have started their termination process and are required to have finished redeterminations before the end of that year. By the end of the redetermination process for all states in 2024, the uninsurance rate will likely be higher than 9.3% and more than 0.1% higher compared to CY 2023 (9.2%).

For example, Arkansas began terminating coverage for Medicaid enrollees in April. Arkansas has reported that 62,711 of all 1.15 million enrollees were disenrolled in April alone.⁵ Additionally, Arizona terminated coverage for 39,831 enrollees in April.⁶ Prior to the end of the continuous enrollment requirement Arizona had almost 2.5 million individuals enrolled in Medicaid.⁷ We will likely see continued termination of thousands of enrollees over the next several months in Arkansas and Arizona. Nationwide over 500,000 enrollees have lost coverage as of the end of May 2023, or less than two months after continuous enrollment ended.⁸ While not all states may see such high numbers within one month, it is likely that many states will unenroll tens of thousands of enrollees before or during CY 2024.

Many Medicaid coverage terminations thus far have been due to procedural or administrative reasons rather than ineligibility.⁹ This suggests that the vast majority of enrollees that have lost coverage have not been transitioned to another source of coverage, such as through the Marketplace, and would count as uninsured for DSH purposes.

As states ramp up and complete their Medicaid redetermination process over the next year, NRHA maintains that uninsurance rates will grow. In total, **we believe that the 9.3% uninsurance rate for CY 2024 is inaccurate and CMS should monitor forthcoming data and incorporate it into the final rule to ensure that uncompensated care payments reflect the current coverage landscape.**

V. Other Decisions and Changes to the IPPS for Operating System.

B. Proposed Changes in the Inpatient Hospital Update for FY 2024.

1. Proposed FY 2024 Inpatient Hospital Update.

⁴ Center for Children and Families, Georgetown University, 50-State Unwinding Tracker (Apr. 1, 2023), <https://ccf.georgetown.edu/2023/04/01/state-unwinding-tracker/>.

⁵ Kaiser Family Foundation, Medicaid Enrollment and Unwinding Tracker (May 22, 2023), <https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-state-enrollment-and-unwinding-data/>.

⁶ *Id.*

⁷ *Id.*

⁸ Jennifer Tolbert, et al., *What Do the Early Medicaid Unwinding Data Tell Us?*, KAISER FAMILY FOUNDATION, May 31, 2023, <https://www.kff.org/policy-watch/what-do-the-early-medicaid-unwinding-data-tell-us/>.

⁹ Kaiser Family Foundation, *supra* note 5.

NRHA thanks CMS for the 2.8% increase in payments to IPPS hospitals. NRHA is also pleased to see that this update will be about 2.9% for rural hospitals with less than 50 beds and 3.6% for rural hospitals with less than 150 beds.

However, **this update is inadequate given inflation, workforce shortages, and labor and supply cost pressures that rural hospitals continue to face.** Since 2010, 151 rural hospitals have closed¹⁰ and an estimated 450 additional hospitals are vulnerable to closure.¹¹ Nearly 45% of rural hospitals are operating in the red and the overall median rural hospital operating margin is 1.8%.¹² Losing a hospital is devastating to a rural community as beneficiaries lose a local point of access to care.

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.

NRHA recommends CMS consider how it can use its regulatory authority to boost payments to rural hospitals. Given the historical discrepancies between the projected and actual market basket indexes, hospitals need an adjustment to account for past inadequate payments. Section 1886(d)(5)(I)(i) of the Social Security Act gives the Secretary the authority to make any additional exceptions or adjustments to payments under subsection (d) as deemed necessary.¹³ This would include the IPPS standardized payment amounts. **NRHA urges CMS to consider updating the final payment rate to reflect the difference between prior years' actual and forecasted market basket increases through its exceptions and adjustments authority.**

Congress granted the Secretary broad authority through this provision and NRHA maintains that the current financial pressures that hospitals are experiencing warrant use of this provision. Swift legislative and regulatory action are needed to protect rural hospitals and mitigate the rural hospital closure crisis. **NRHA urges CMS to contemplate use of its exceptions and adjustment authority to improve reimbursement for rural hospitals.**

G. Payments for Indirect and Direct Graduate Medical Education Costs.

NRHA reiterates its comments on Lugar status and IME from section *III.I.3. Redesignations Under Section 1886(d)(8)(B) of the Act (Lugar Status Determinations)*, *supra*.

¹⁰ 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).

¹¹ Michael Topchik, et al., *Rural Health Safety Net Under Renewed Pressure as Pandemic Fades*, The Chartis Group (2023), 4 https://www.chartis.com/sites/default/files/documents/chartis_study_rural_health_safety_net_under_renewed_pressure_as_pandemic_fades.pdf.

¹² *Id.* at 3.

¹³ 42 U.S.C. § 1395ww(d)(5)(I)(i) (“The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate”).

2. Calculation of Prior Year IME Resident to Bed Ratio When There is a Medicare GME Affiliation Agreement.

The policy to use a GME affiliation agreement specifically for rural tracks may be problematic for residency programs. The “Rural Track Medicare GME Agreement” finalized in the FY 2023 IPPS rule allows, in specific circumstances, the sharing of cap slots between hospitals and cross-training of residents. NRHA raises concerns that have grown since the policy was finalized last year. We recommend that CMS set the caps associated with rural training programs and provide special consideration to the rural hospital by counting the highest year, rather than all five years when setting the cap.

The process of distributing caps between rural and urban hospitals may be inequitable as it provides the urban hospital with more slots than it needs for the residents training in a rural track and provides the rural site less fulltime equivalents (FTE) than it would typically need. The inequitable distribution of FTE caps is not solved by CMS’ affiliation agreement policy and can create financial barriers for rural residency programs. Additionally, the Rural Track Agreements policy is too narrow and is limited only to family medicine training. Across the country, new rural residencies in other specialties are being created in general surgery, psychiatry, and internal medicine with flexibilities afforded by recent omnibus bills.

Affiliation agreements have the potential to disadvantage rural hospitals as urban hospitals are unlikely to share the “rural FTE limitation” slots to benefit a participating rural hospital’s cap. Urban hospitals have the ability to assume costs for a rural training track other than residents’ salary and benefits and alleviate any inequity that may have occurred in cap distribution in the past. It does not require a separate RTP affiliation agreement now or in the future.

CMS has the authority to make changes to the rural cap limitations for hospitals participating in rural training and is not restricted to only sharing positions through an affiliation agreement. CMS should set caps appropriately to reflect the true time residents are spending in rural hospitals to ensure long-term sustainability. Allowing affiliation agreements is inadequate for the following reasons:

- Establishing an additional, annual process that requires negotiation and attestations is more cumbersome for all parties to engage in to ensure equal distribution of slots. Furthermore, there is no guarantee the urban hospital will approve sharing of slots with the rural hospital and there is no recourse for a rural hospital that is not granted slots by the urban affiliate.
- Sharing slots can create an urban-centric power differential. The urban hospital (which may be over its FTE cap) has little incentive to share slots with a rural hospital.

3. Training in New Rural Emergency Hospital Facility Type.

NRHA thanks CMS for including rural emergency hospitals (REH) as graduate medical education (GME) eligible facilities. **We support CMS’ proposal to treat REHs similarly to critical access hospitals (CAHs)** for GME purposes and allow facilities to choose whether to be treated a nonprovider site or incur the costs of training residents and receive payment based upon 100% of reasonable costs.

NRHA asks that CMS adopt cost-based reimbursement of 101% for REHs that choose to incur the costs of resident training in the final rule. CAHs currently receive 101% of reasonable costs

for training residents and CMS should maintain consistency for those that convert to REH status. Hospitals that choose to convert to an REH do not make the decision lightly and are more likely to be independent CAHs, have a three-year negative operating margin, and have a relatively low average daily census.¹⁴ Hospitals that convert and decide to train residents are doing so while in a precarious financial position and thus should receive higher reimbursement. Moreover, aligning this policy with CAHs is consistent with CMS' approach in other areas of law for REHs, such as mirroring many CAH conditions of participation for REHs.

IX. Proposed Quality Data Reporting Requirements.

C. Proposed Changes to the Hospital Inpatient Quality Reporting Program (IQR).

9.a. Potential Future Inclusion of Two Geriatric Care Measures.

NRHA appreciates CMS' commitment to improving outcomes for older Americans. Rural populations tend to be older than urban populations¹⁵ and this trend will likely continue as the overall U.S. population rapidly ages.¹⁶ As such, NRHA agrees that focusing on optimizing care for older adults is an important goal for hospitals.

Older adults are an important subset of the rural population. While the rural population is smaller than urban and suburban populations, adults over sixty-five make up a disproportionate share of rural residents compared to other geographic populations.¹⁷ **NRHA agrees that rural hospitals should focus on protecting and ensuring good health outcomes for older adults.** In particular, older rural Americans are more likely to have complex care needs, more social risk factors, and multiple chronic conditions that require high-quality care. This means that rural hospitals may see higher resource utilization when caring for older rural adults.

However, **NRHA maintains that the benefits to patients and the hospital must outweigh the administrative burden associated with new reporting requirements.** NRHA concurs with the Measures Application Partnership (MAP) Rural Health Advisory Group that the hospital measure is important, but rural hospitals are critically understaffed and would face more challenges to consistently documenting and reporting.¹⁸ While attestation based measures are usually less onerous than others, the main burden for staff would be assessing whether the hospital is doing each of the activities listed in the measures.

¹⁴ George Pink, et al., *Characteristics of Rural Hospitals Eligible for Conversion to Rural Emergency Hospitals and Three Rural Hospitals Considering Conversion*, NC RURAL HEALTH RESEARCH PROGRAM, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, December 2022.

¹⁵ Kim Parker, et al., *Demographic and economic trends in urban, suburban and rural communities*, Pew Research Center, May 22, 2018, <https://www.pewresearch.org/social-trends/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/>.

¹⁶ Jonathan Vespa, *The Graying of America: More Older Adults Than Kids by 2035*, U.S. CENSUS BUREAU (Mar. 13, 2018) <https://www.census.gov/library/stories/2018/03/graying-america.html>.

¹⁷ Amy Symens Smith and Edward Trevelyan, *American Community Survey Reports: The Older Population in Rural America*, U.S. CENSUS BUREAU (Sept. 2019), <https://www.census.gov/content/dam/Census/library/publications/2019/acs/acs-41.pdf>.

¹⁸ National Quality Forum, Measure Applications Partnership (MAP) Hospital Workgroup: Preliminary Analyses, December 1, 2022, at 43, <https://mmshub.cms.gov/sites/default/files/2022-preliminary-analysis-hospital-workgroup.pdf>.

The two geriatric care measures address a current gap in the IQR Program, but NRHA does not see a strong patient or provider benefit to reporting on the measures as they stand. As the MAP Hospital Workgroup noted of the hospital measure, there is no clear link between attestation and improving patient outcomes because many questions assess provider infrastructure.¹⁹

NRHA asks that CMS use one combined measure if it moves forward with geriatric quality measures in a future rulemaking cycle. The MAP Hospital Workgroup's preliminary recommendation on the hospital measure is similar. The workgroup recommends cross-walking both measures in order to create one less burdensome measure. Many of the domains and the questions under each domain are the same in both the geriatric hospital measure and geriatric surgical measure. Reporting on both would be duplicative considering that the hospital-wide measure pertains to general health outcomes, which would necessarily include outcomes for surgical patients. Reporting on the same domains for the whole hospital and for one department is an additional administrative burden that NRHA does not believe outweighs the benefit.

9.b. Potential Establishment of a Publicly Reported Hospital Designation to Capture the Quality and Safety of Patient-Centered Geriatric Care.

Again, NRHA's support for establishing a geriatric hospital designation depends upon the benefit compared to the administrative burden and resources needed to achieve such designation for small rural hospitals. In general, NRHA may support a designation as an incentive to provide quality care to older rural beneficiaries if CMS can also incentivize hospitals to seek the designation.

However, **NRHA cautions CMS against reporting measures and hospital designations that can inadvertently exclude rural hospitals from the benefits of such designations.** Similar to the birthing friendly designation finalized in 2022,²⁰ various factors, like staff shortages, may prevent a rural hospital from positively attesting to the reporting measures and subsequently receiving the hospital designation. **NRHA also warns CMS against implementing any penalties against hospitals that cannot achieve a designation.** Achieving a designation should be optional and only impact the hospitals that receive it.

Providing technical assistance to hospitals could increase rural participation in a future geriatric hospital designation. A designation should be an optional achievement and rural hospitals are not in a position to take on any extra, elective reporting requirements. Typically, rural hospitals do not have a robust dedicated administrative staff. If a hospital does, it is a small team that handles all administrative tasks. Rural hospitals require targeted assistance from CMS to help them meet the goals and measures that make up the designation.

Payment incentives associated with a hospital designation may increase rural participation. On its own the designation would not provide direct financial incentives to rural hospitals. In fact, rural hospitals are likely disincentivized from pursuing a designation because of the costs associated and limited financial resources. But financial assistance from CMS, or from other agencies that may partner with CMS to help rural hospitals, may encourage more rural hospitals to participate.

¹⁹ *Id.* at 41.

²⁰ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals, 87 Fed. Reg. 48,780, 49,282 (Aug. 10, 2022) (to be codified at 42 C.F.R. pts. 412, 413, 482, 485, and 495).

Assistance may look like a grant to help meet any requirements or payment boosts for hospitals that have the designation. Without technical assistance or additional money small, rural, and under-resourced hospitals will likely not benefit from any future geriatric designation.

X. Other Provisions Included in this Proposed Rule.

A. Rural Emergency Hospitals (REHs).

NRHA thanks CMS for codifying guidance on documentation for hospitals' REH applications and enrollment. More detailed information on action plans for conversion provides clarity and consistency for rural hospitals that seek the new designation.

D. Safety Net Hospitals – Request for Information.

NRHA appreciates CMS' interest in further supporting safety net hospitals. Attempting to comprehensively define and identify safety net hospitals is a daunting task, but **NRHA firmly believes that the core of any definition must be the hospital's essential ability to service patients that would otherwise not have local access to care.** In addition to local access, NRHA urges CMS to consider patient and community demographics as the primary facet of safety net hospitals in its pursuit of a definition.

- How should safety-net hospitals be identified or defined?

One tenet of safety net hospitals should be their role in sustaining access in an area or community that would otherwise not have health care access. To an extent, as discussed below, certain CMS designations capture this. For example, CAHs generally must be thirty-five miles from the nearest hospital to qualify for the designation. Sole community hospitals also must meet similar distance criteria. On the other end of the spectrum, MedPAC's proposed Safety Net Index does not consider mileage at all, which is also problematic. NRHA asks that a future safety net definition use multiple indicators, including those that are more precise than mileage alone. In general, **safety net hospitals should provide critical services in an underserved area.**

One way to identify an underserved area is to look at providers other than hospitals as well. Hospitals in areas without other typical rural safety net providers, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs), may have even more of a safety net role compared to hospitals with nearby clinics. As of 2018, more than 17 million rural residents live in counties without an RHC and more than 15 million live in a county without an FQHC.²¹ These rural residents likely rely upon hospitals as their nearest and most accessible point of care, making those hospitals more likely to be safety net. **The availability of alternate providers should be one, but not the only, way to measure whether a hospital is providing services in an underserved area.** NRHA notes that hospitals with provider-based clinics are also crucial safety net providers and should not be excluded.

The availability of services in a particular catchment area may also be an identifier for safety net hospitals as well. A hospital that maintains a service line, such as labor and delivery, in an area that otherwise has no access to that service should be identified as a safety net hospital. While another hospital may be nearby, location is not a perfect indicator of safety net status in this situation

²¹ Meagan Clawar, et al., *Access to Care: Populations in Counties with No FQHC, RHC, or Acute Care Hospital*, NC RURAL HEALTH RESEARCH PROGRAM, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, January 2018, https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/01/AccessstoPrimaryCare.pdf.

because an important service is not available at the other hospital. CMS should consider a population's proximity to essential service lines, like obstetric units, when identifying safety net hospitals.

Financial status or vulnerability should also help identify safety net hospitals when combined with the previous two access criteria. Hospitals that continuously have negative or low operating margins likely serve the patient population that NRHA believes can help identify a safety net hospital. Additionally, financial status overlaid with location (i.e., recognizing a hospital's ability to provide access in an underserved area) could identify many rural safety net hospitals.

Accordingly, **uncompensated care is a useful predictor of safety net status for rural hospitals.** One study found that uncompensated care captured smaller and more rural safety net hospitals while DSH index and Medicaid caseload identified larger teaching facilities.²² Further, median uncompensated care as a percentage of a hospital's operating expense was highest for rural prospective payment system (PPS) hospitals, followed by CAHs and was lowest for urban PPS hospitals.²³ These findings suggest that higher levels of uncompensated care in rural hospitals may be associated with their role as a rural safety net hospital.

Safety net hospitals should also be identified by their patient population. Currently, the calculation for DSH payments places too much emphasis on Medicaid and uninsured patients. One way that MedPAC's safety net index improves upon DSH is that it does consider Medicare patient loads. Identifying patients by their payer, or lack of a payer, is helpful but current policies and proposals place an undue weight on these identifiers. Rural hospitals uniquely rely upon public payers, Medicaid and Medicare, as their primary payers compared to urban areas.²⁴ Excluding or undervaluing public payers, especially Medicare, will be a detriment to rural safety net hospitals.

One way that area level indices may be useful is by identifying the community- and patient-level demographics and what social determinants of health (SDOH) these populations face. Rural populations tend to be older, sicker, and poorer. Hospitals that serve larger numbers complex, higher-needs patients with more social risk factors are likelier to be safety net hospitals. This means that hospitals that serve more acute or sicker patients are providing costlier care compared to those that do not. In addition, SDOH affect health outcomes and status, with social and economic factors accounting for up to 40% of health outcomes and health behaviors and physical environment accounting for 30% and 10% respectively.²⁵ Rural populations have lower incomes and higher poverty rates than their urban counterparts.²⁶

NRHA recognizes that current area level indices, like the area deprivation index, may not be the best indicator to determine SDOH. CMS should ensure that the data feeding into indices is accurate and

²² Ioana Popescu, et al., *Comparison of 3 Safety-Net Hospital Definitions and Association With Hospital Characteristics*, JAMA NETWORK OPEN, Aug. 2019, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2747477>.

²³ Krystal G. Garcia, et al., *Geographic Variation in Uncompensated Care between Rural and Urban Hospitals*, NC RURAL HEALTH RESEARCH PROGRAM, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, June 2018, https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/06/Geographic-Variation-in-Uncompensated-Care-between-Rural-Hospitals-and-Urban-Hospitals.pdf.

²⁴ Timothy McBride, et al., *supra* note 3.

²⁵ University of Wisconsin Population Health Institute, *County Health Rankings Model*, <https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model>.

²⁶ MACPAC, *supra* note 3.

representative, especially for rural areas. When a metric is based upon faulty data, the metric does not accurately capture what it is supposed to. For example, data that inform area level indices for rural areas may be inaccurate because of low volumes and understaffed or under-resourced reporting sources, like local public health departments. **CMS must not use metrics that are fed by data that do not reflect the full or correct picture of rural areas and populations.**

- What factors should not be considered when identifying or defining a safety-net hospital and why?

CMS should not use volume-based metrics. Volume-based measures and definitions inherently disadvantage rural hospitals. Generally, rural hospitals have a much lower patient volume and average daily census than other hospitals. The number of patients served by a hospital should not be included in any definition.

- What are the different types of safety-net hospitals?

Right now, hospitals that could be considered safety net facilities are identified through different payment designations like CAHs, sole community hospitals (SCH), Medicare-dependent hospitals (MDH), low volume hospitals, and disproportionate share hospitals (DSH). Most of these designations are applicable to hospitals located in both rural or urban areas and likely identify a large proportion of all safety net hospitals through a few characteristics, including geographic location and patient types.

Geographic location in current payment designations mostly denotes that a hospital is the only hospital in some defined area. For example, CAHs are generally at least thirty-five miles from another hospital. Similarly, SCHs must be thirty-five miles from another like hospital or in a rural area located fifteen to thirty-five miles from another hospital depending upon other criteria.²⁷ To an extent, DSH hospitals rely upon patient types by looking at the share of Medicaid and Medicare SSI beneficiaries as well as the percent of the population that is uninsured.

As discussed above, looking at payer mix and relative distance from another hospital are likely not the only features of safety net hospitals, although they can be important indicators when used in combination with other criteria. Another commonly used definition is from the National Academies of Science, Engineering, and Medicine (NASEM), which defines safety net hospitals as providers that “organize and deliver a significant level of health care and other needed services to uninsured, Medicaid and other vulnerable patients.”²⁸ This aligns with our belief that one criteria of safety net should look at patients. The NASEM definition also captures many different types of hospitals with a variety of sizes, locations, ownership, financial status.

- What are particular challenges facing rural safety-net hospitals?

NRHA members consistently express that their biggest challenges are financial, including inadequate Medicare and Medicaid reimbursement. We reiterate our concerns from section *V.B.1. Proposed FY 2024 Inpatient Hospital Update* over the proposed FY 2024 payment update and the challenges that rural hospitals face related to payment. Rural hospitals rely heavily upon Medicare and Medicaid as primary payers and need more robust payment rates to reflect their fixed overhead costs and lower volumes of services. Non-PPS hospitals, like CAHs, receive 101% of

²⁷ 42 C.F.R. § 412.92(a).

²⁸ Agency for Healthcare Research and Quality, Department of Health and Human Services, *Safety Net*, <https://www.ahrq.gov/topics/safety-net.html>.

reasonable costs, however, the true reimbursement levels are below that due to sequestration and other adjustments. Similarly, due to sequestration, CAHs are paid below costs (99%) and actually lose money providing services to Medicare beneficiaries. Payment adjustments and add-ons, like DSH or SCH payments, partially make up for costs where public payers fail to reimburse for the full costs of care. As rural hospital closures begin to tick up again, defining and protecting safety net hospitals is crucial.

- How helpful is it to have multiple types or definitions of safety-net hospitals that may be used for different purposes or to help address specific challenges?

One comprehensive safety net definition may fail to capture the heterogeneity of hospitals and the communities they serve and thus inadvertently exclude some true safety net providers. More than one type or definition may be helpful to ensure that all safety net hospitals are included. One recent study compared three definitions of safety net to understand the types of hospitals that were captured in each.²⁹ The study concluded that each definition encapsulated a different set of hospitals with limited overlap between the definitions.³⁰ This suggests that one definition may not be sufficient.

- Are there social determinants data collected by hospitals that could be used to inform an approach to identify safety net hospitals? Are there HHS or CMS policies that could support that data collection?

For rural hospitals, there is likely little to no social determinants data currently collected that could inform an approach to identifying safety net hospitals. ICD-10-CM codes Z55 – Z65, or “Z codes” capture factors that influence health status and contact with health services and can be used as principal or secondary diagnoses.³¹ However, rural hospitals’ participation in voluntary Z code reporting has been limited and faces a number of challenges.³² CMS solicited comments on the uptake of Z coding in hospitals in last year’s proposed IPPS rule. NRHA is incorporating its response by reference.³³ Overall, **NRHA is concerned that using current SDOH data would exclude rural hospitals that do not have the capacity to collect such information.**

Increased use of Z codes would give providers and CMS valuable insight into the social risk factors that most impact their patient populations. NRHA reiterates our past comments on the additional burden of Z coding on rural providers.³⁴ Lack of training, adequate infrastructure, resources, administrative personnel, and trust of providers by patients make implementing Z coding difficult for rural hospitals. However, technical assistance, including financial assistance, would aid rural hospitals in beginning to use Z codes. In the future this data could be used to identify safety net hospitals if a SDOH-based measure were adopted.

²⁹ Popescu, *supra* note 22.

³⁰ *Id.*

³¹ Elizabeth Hall-Lipsy, Joseph Robare, & Jeanne Edevold Larson, *Integrating Z coding for social determinants of health and its impact on rural areas*, NATIONAL RURAL HEALTH ASSOCIATION (Feb. 2023), 1, https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2023/NRHA-Policy-Brief-Final-Draft-SDoH.pdf.

³² *Id.*

³³

https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2022/NRHA-FY23-IPPS-Final-Comment.pdf.

³⁴ *Id.*



National Rural Health Association

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 for rural residents. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan".

Alan Morgan
Chief Executive Officer
National Rural Health Association