Add date of submission

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare and Medicaid Services

7500 Security Blvd.

Baltimore, MD 21244

**RE: CMS-1809-P;** Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities.

***Submitted electronically via regulations.gov.***

Dear Administrator Brooks-LaSure.

[Your organization] 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) 2025. We appreciate CMS’ continued commitment to the needs of rural Americans, and we look forward to our continued collaboration to improve health care access in our rural community.

[Insert short description of your organization.]

**II. Proposed Updates Affecting OPPS Payments.**

*B. Proposed Conversion Factor Update.*

[Your organization] thanks CMS for its 2.6% payment update relative to CY 2024. **We are pleased to see that rural hospitals across the board will have a slightly higher payment update at 2.8%.** However, **we continue to be concerned about the discrepancy between Medicare payment rates and actual inflation.** For July 2024, the Consumer Price Index for hospital services was 6.1% meaning that Medicare reimbursement will continue to fall behind the actual cost of providing care to beneficiaries.[[1]](#footnote-2) 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.

**It is critical that CMS explores how it can accurately pay rural hospitals by accounting for inflation and historical underpayment.** Nearly 180 rural hospitals have closed or ceased inpatient services since 2010, the majority of which were PPS hospitals.[[2]](#footnote-3) Estimates show that an additional 418 rural hospitals are vulnerable to closure.[[3]](#footnote-4) [Discuss the importance of adequate Medicare reimbursement to your hospital. For example, what percentage of your patient population is covered by Medicare? Discuss any financial challenges you are facing that you feel comfortable sharing.]

**We also support 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 that play an essential role in their community. 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 that MDHs incur and make an adjustment similar to what SCHs receive to help support the rural health safety net.

VII. Proposed OPPS Payment for Hospital Outpatient Visits

In the CY 2023 OPPS final rule, CMS finalized a policy to exempt rural SCHs from its policy to pay for hospital outpatient clinic visits furnished at off-campus provider-based departments at the Medicare Physician Fee Schedule (MPFS) rate, or 40% of the OPPS rate. CMS proposes to continue this exemption and [your organization] supports this proposal. [If you qualify for this exemption, discuss its importance to your hospital.]

**We urge CMS to 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. [If your hospital has one of these designations, discuss how being eligible for this exemption would benefit your hospital.]

Since 2010, 28 MDHs have closed their doors. GAO likewise found that Medicare profit margins and total hospital profit margins declined for MDHs from fiscal year 2011 through 2017, from -6.9% to -12.9% and 1.6% to -0.2%, respectively.[[4]](#footnote-5) The degree to which Medicare margins declined for MDHs during this time period (6%) was greater than the degree to which they declined for rural hospitals (3.8%) and all hospitals (2.5%).[[5]](#footnote-6) Extending this site neutral exemption to MDHs would ensure rural hospitals receive more adequate reimbursement and thus support access to care for beneficiaries in rural areas. **CMS must finalize its proposal to continue to exempt rural SCHs and extend the same relief to MDHs.**

VIII. Payment for Partial Hospitalization (PHP) and Intensive Outpatient (IOP) Services.

## *C. Proposed CY 2025 Payment Rates for PHP and IOP.*

CMS finalized the new Medicare IOP benefit in the CY 2024 OPPS final rule. Payment rates for IOP services will be updated each year. This year CMS proposes to increase payment for 3-service days at hospitals to $279.97 and 4-service days to $428.39. **[Your organization] supports CMS’ proposed payment rate increase for PHP and IOP services.**  [Are your providing IOP services? If not, please expand upon why you are not able to provide these services, including any barriers.]

X. Nonrecurring Policy Changes.

## *B. Virtual Direct Supervision of Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), Pulmonary Rehabilitation (PR) Services and Diagnostic Services Furnished to Hospital Outpatients.*

CMS proposes to continue its flexibility to allow the availability for virtual direct supervision of CR, ICR, and PR services through December 31, 2025. **[Your organization] appreciates this extension and urges CMS to finalize it.** A continuation of this policy is key for providers because they need time to reorganize and readjust policies to meet pre-Public Health Emergency (PHE) rules again. Include any relevant information on how this policy has helped workflow at your hospital.]

## *C. All-Inclusive Rate (AIR) Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities.*

**[Your organization] supports CMS’ proposal to pay Indian Health Service (IHS) and tribal hospitals separately for high-cost outpatient drugs.** We agree with CMS’ conclusion that paying separately for these drugs will enable IHS and tribal hospitals to continue to or begin to provide much-needed specialty care. [Include any relevant information on how this policy will impact your hospital.]

XVIII. Medicaid Clinic Services Four Walls Exceptions.

## *B. Provisions of the Proposed Regulations.*

States may offer Medicaid clinic services as an optional benefit category. One requirement for this benefit is that Medicaid clinic services be furnished onsite. This is referred to as the “four walls” requirement. CMS proposes to expand the exceptions to the four walls requirement to clinics in rural areas, IHS and tribal clinics, and behavioral health clinics. **[Your organization] supports these proposed exceptions as they will foster access to care for rural and tribal communities.**

CMS is soliciting comments on how to define rural for the purposes of exempting clinics from the four walls requirement. CMS is considering whether to apply a federal definition, allow states to adopt a state or federal definition, or to not define rural at all. **[Your organization] suggests that CMS allow states to choose a state *or* federal definition of rural in order to meet their unique geographic needs.** Oftentimes when CMS applies a broad definition, like Metropolitan Statistical Area (MSA) or non-MSA to policies, certain rural communities are improperly grouped with urban areas. Giving states the ability to choose a state or federal definition that works best for their rural communities will ensure that clinics that would most benefit from the exception are eligible. Alternatively, CMS could use the Federal Office of Rural Health Policy definition[[6]](#footnote-7) of rural to establish exemption criteria.

[Include any relevant information on how this policy will impact your clinic.]

XIX. Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process.

**[Your organization] applauds CMS for shortening the prior authorization timeline for Medicare fee-for-service (FFS) outpatient requests to 7 calendar days.** We appreciate that CMS is aligning the timeline for standard outpatient department requests with that of other payers. This proposal will create equity for all patients waiting to access care and may help reduce provider burden by streamlining processes across all payers. [Include any relevant information on how this policy will impact your hospital.]

XX. Provisions Related to Medicaid and the Children’s Health Insurance Program (CHIP).

## *A. Continuous Eligibility in Medicaid and CHIP (42 CFR 435.926 and 457.342).*

**[Your organization] commends CMS for its work to ensure children remain covered by Medicaid and CHIP.** Medicaid is an important source of coverage for rural residents and a critical payer for rural hospitals. Importantly, **Medicaid and CHIP cover almost half of all rural children.[[7]](#footnote-8)** Rural residents are more likely to be low-income and unemployed[[8]](#footnote-9) and for individuals that are employed, rural employers are less likely to provide insurance.[[9]](#footnote-10) Thus Medicaid fills in gaps in coverage and access in rural America. As such, **we strongly support CMS’ proposal to make continuous eligibility for children enrolled in Medicaid and CHIP a requirement for state Medicaid plans.**

[Discuss how this change will benefit your patient population.]

XXI. Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals.

[Your organization] commends CMS for its continued focus on ending rural maternal health disparities. **Between 2011 and 2021, 267 rural hospitals ceased providing obstetrical (OB) care, representing 25% of rural America’s OB units.[[10]](#footnote-11)** These closures are threatening access to care and contributing to the rural maternal health crisis. Unfortunately, as rural hospitals face difficult financial situations, closing service lines is an intermediary step before closing the hospital. Given the low volume of births in rural areas, coupled with financial challenges and workforce shortages generally experienced by rural hospitals, OB units are one of the first service lines to be ended.

To help address maternal health outcomes nationwide, CMS proposes new OB services conditions of participation (COPs) and amendments to emergency services and Quality Assessment and Performance Improvement (QAPI) COPs. We appreciate CMS’ goal of improving maternal health outcomes so long as rural access to care is not inadvertently threatened.

## *B. Provisions of the Proposed Regulations.*

**[Your organization] urges CMS to exempt rural hospitals and CAHs from the proposed COPs.** Again, weagree with and supports CMS’ mission to address and improve maternal health outcomes. **However, we are extremely concerned with the current trend of OB unit closures and the impact that complying with requirements in the new COPs will have on the remaining OB units in rural hospitals.** **We maintain that imposing one-size-fits-all COPs on rural hospitals and CAHs will lead to more OB unit closures.** Research suggests that lack of access to hospital-based OB care worsens outcomes and lowers the likelihood of adequate prenatal care.[[11]](#footnote-12) **Imposing additional COPs on vulnerable rural hospitals and CAHs will ultimately cut against CMS’ goal of improving maternal health outcomes.** Rural hospitals disproportionately rely upon Medicare and Medicaid reimbursement as they make up the majority of their patient population. **The magnitude of the effect of not complying will have a chilling effect on rural hospitals such that they will preemptively cease providing OB care to preserve their participation in Medicare and Medicaid.**

[Describe the importance of your hospital providing OB care in your community. How would patient access be affected if you had to stop providing services?]

Further, CMS is soliciting comments on whether the proposed COPs should apply to rural emergency hospital (REHs). **[Your organization] strongly urges CMS against applying OB and related COPs to REHs.** REHs have their own distinct set of COPs that in many places, but not all, align with CAH COPs. The REH designation was created as a lifeline for certain rural hospitals that may otherwise close. As such, REHs have their own distinct payment methodology and COPs and should not be required to comply with COPs that other rural hospitals do.

1. Organization, Staffing, and Delivery of Services (§ 482.59 and § 485.649).

CMS proposes COPs related to the organization, staffing, and delivery of services in an OB unit. Many of the proposals may already be happening in rural hospitals, such as maintaining a roster of practitioners’ privileges or training relevant OB staff on maternal care. **However, it is not appropriate to mandate these practices with the threat of noncompliance resulting in loss of Medicare and Medicaid participation.** We appreciate the flexibility given in certain areas such as not prescribing who or how hospitals train staff on OB care and allowing flexibility around which evidence-based guidelines to use for developing protocols around OB emergencies. **Nonetheless, we do not believe additional mandates are the answer to improving maternal health in rural areas and urge CMS to relieve rural hospitals and CAHs of these requirements.**

[Discuss the impact of the newly proposed OB COPs on your hospital. What would the burden be (time, staff, cost, etc.)? To what extent are you already doing some of these activities and what is the impact of being required to do so through COPs? Find more details on the COPs from our OPPS listening session [here](https://nrha-prod-eastus-be.azure.silvertech.net/NationalRuralHealth/media/Documents/Advocacy/2024/CY25-OPPS-listening-session-8-6-24.pdf).]

We are particularly concerned around requirements for equipment at proposed § 482.59(b) § 485.649(b). CMS proposes that hospitals and CAHs have a call-in-system, cardiac monitor, and fetal doppler or monitor available to labor and delivery room suites. We ask that CMS clarify its definition of “available.” Many rural hospitals and CAHs likely have this equipment available to the unit but not in every labor and delivery room. CMS should allow flexibility around equipment requirements and allow hospitals to have this equipment available in relation to patient needs. For example, if a CAH typically has one patient in its OB unit at any given time, one set of equipment for the unit should be sufficient to meet this requirement.

**One way CMS can help improve rural maternal health outcomes is to assist rural hospitals with OB readiness. [Your organization] asks that CMS provide resources, such as technical assistance, to help rural hospitals achieve this goal.** A broad emergency services readiness COP, described below in Section 3, is redundant and will not further readiness for OB emergencies. For example, S. 4079/H.R. 8383, the Rural Obstetric Readiness Act[[12]](#footnote-13) would help prepare rural hospitals and providers to handle the obstetric emergencies that come into their emergency rooms. This would be achieved through supporting facilities with the purchase of necessary equipment and developing a workforce that is able to respond, creating a pilot program to support statewide or reginal networks of obstetric care teams to provide tele-consultation, and creating an obstetric emergency training program for rural facilities that do not have a labor and delivery unit. While this program would be housed in the Health Resources and Services Administration, it can serve as a model for the kind of technical assistance that CMS could help provide.

3. Quality Assessment and Performance Improvement (QAPI) Program (§ 482.21; § 485.641).

CMS proposes that hospitals and CAHs that offer OB services be required to use their QAPI programs to assess and improve outcomes and disparities among OB patients. Again**, [your organization] urges CMS to exclude rural hospitals and CAHs from this proposal.**

If CMS moves forward with finalizing this proposal, we ask that CMS provides flexibility around the requirement to incorporate Maternal Mortality Review Committee (MMRC) data and recommendations into hospitals’ QAPI programs. Almost every state has a statewide MMRC meaning that their state data or recommendations may be more urban-centric and not relevant to or representative of rural hospitals. CMS should allow hospitals to instead use data and recommendations from any body that is working on OB quality in their area.

[How would the QAPI changes impact your hospital? To what extent are you already measuring and analyzing OB outcomes?]

4. Emergency Services Readiness (§ 482.55; § 485.618).

**[Your organization] urges CMS against finalizing this addition to emergency services COPs.** The new provisions under § 482.55 and § 485.618 would apply to all emergency services. **These provisions are redundant as hospitals and CAHs must meet existing emergency services COPs and comply with EMTALA.** Adding an additional set of emergency services COPs on rural hospitals and CAHs will be a financial, administrative, and staff burden that many of these struggling providers cannot shoulder.

**The proposed provisions are duplicative for CAHs in particular and must not be finalized.** The new proposals would require adequate provisions and protocols to meet the emergency needs of patients. CAHs are already meeting a similar, if not almost identical, standard at § 485.618(b)-(c). Additionally, CMS proposes to add that CAHs must have a physician immediately available by phone on a 24/7 basis to receive emergency calls, provide information on treatment, and refer patients to the CAH or another location. Yet CAHs must currently comply with a similar requirement in § 485.618(d) which requires that a practitioner be on call or immediately available by phone and available onsite within 30 minutes on a 24-hour basis.[[13]](#footnote-14) CMS’ proposal would require that a physician, rather than a non-physician practitioner, be available by phone 24/7, which is more difficult to meet in the face of the workforce shortages that CAHs experience. **We assert that CAHs are presently meeting an extremely similar standard regarding emergency services and the existing standard was designed with rural workforce limitations in mind.** Therefore new one-size-fits-all standards are not appropriate and will result in additional untenable burdens for CAHs.

[Explain how the new emergency services COP would impact your hospital. To what extent are you doing similar activities and how will a COP make it potentially more difficult? Find more details on the COPs from our OPPS listening session [here](https://nrha-prod-eastus-be.azure.silvertech.net/NationalRuralHealth/media/Documents/Advocacy/2024/CY25-OPPS-listening-session-8-6-24.pdf).]

Thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work together towards our mutual goal of improving health care and access for rural Americans. If you have any questions or would like to discuss further, please contact [name] at [email].

Sincerely,

[Insert e-signature]

Name

Title

Organization

1. Press Release, Bureau of Labor Statistics, Department of Labor, Consumer Price Index – July 2024 (Aug. 14, 2024), <https://www.bls.gov/news.release/pdf/cpi.pdf>. [↑](#footnote-ref-2)
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/programsprojects/rural-health/rural-hospital-closures/>; Rural Emergency Hospitals, 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-emergency-hospitals/> (this number includes hospitals that converted to another hospital type, such as the Rural Emergency Hospital designation). [↑](#footnote-ref-3)
3. Michael Topchik, et al., *Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory*, Chartis Center for Rural Health (2024), 7 <https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf>. [↑](#footnote-ref-4)
4. Government Accountability Office, *Information on Medicare-Dependent Hospitals*, (Feb. 2020), 21 <https://www.gao.gov/assets/gao-20-300.pdf>. [↑](#footnote-ref-5)
5. *Id.* [↑](#footnote-ref-6)
6. *See* Health Resources and Services Administration, *Defining Rural Population*, last updated January 2024, <https://www.hrsa.gov/rural-health/about-us/what-is-rural>. [↑](#footnote-ref-7)
7. Aubrianna Osorio, Joan Alker, & Edwin Park, *Medicaid’s Coverage Role in Small Towns and Rural America*, Georgetown Center for Children and Families, Georgetown University McCourt School of Public Policy, Aug. 17, 2023, <https://ccf.georgetown.edu/2023/08/17/medicaids-coverage-role-in-small-towns-and-rural-areas/>. [↑](#footnote-ref-8)
8. Julia Foutz, Samantha Artiga, & Rachel Garfield, *The Role of Medicaid in Rural America*, Kaiser Family Foundation, Apr. 25, 2017, <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>. [↑](#footnote-ref-9)
9. Center for Budget and Policy Priorities, *Medicaid Works for People in Rural Communities* (Jan. 19, 2018) <https://www.cbpp.org/research/health/medicaid-works-for-people-in-rural-communities>. [↑](#footnote-ref-10)
10. Topchik, et al., *Rural America’s OB Deserts Widen in Fallout From Pandemic*, Chartis (2024), 1, <https://www.chartis.com/sites/default/files/documents/rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf>. [↑](#footnote-ref-11)
11. Stephanie M. Radke, et al., *Closure of Labor & Delivery units in rural counties is associated with reduced adequacy of prenatal care, even when prenatal care remains available*, 39 J. Rural Health 746, 750 (2023) <https://onlinelibrary.wiley.com/doi/epdf/10.1111/jrh.12758>. [↑](#footnote-ref-12)
12. Rural Obstetrics Readiness Act, S. 4079, 118th Cong. (2024) <https://www.congress.gov/bill/118th-congress/senate-bill/4079>. [↑](#footnote-ref-13)
13. In frontier areas, the practitioner must be available within 60 minutes. [↑](#footnote-ref-14)