National Rural Health Association

June 10, 2024

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

RE: CMS-1808-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.

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) 2025. 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.

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

G. Wage Index Adjustments: Rural Floor, Imputed Floor, State Frontier Floor, Out-Migration Adjustment, Low Wage Index, and Cap on Wage Index Decrease Policies.

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

NRHA supports continuing the low wage index policy for rural hospitals for *at least* three more years. We concur with CMS' position that there is not sufficient data to support modifying or discontinuing the policy because of the COVID-19 pandemic impacts on wage data.

In the FY 2024 rulemaking cycle NRHA suggested that the policy should continue through FY 2030 to ensure there is adequate post-pandemic wage data to support keeping or ending the policy.[1] **NRHA continues to believe that this policy should be extended through *at least* FY 2030.** As CMS notes, the first full FY of wage data after the COVID-19 public health emergency ended would be FY 2028. CMS began this policy in FY 2019 and intended to keep it in place for 4 fiscal years to determine its effectiveness. The policy must be in place through at least FY 2030 to meet this goal.

[1] https://www.ruralhealth.us/getmedia/b6cf8d5a-704f-4f4d-80be-645a8fcc7ad6/FY24-IPPS-proposed-rule-comment-6-9-23.pdf.

IV. Payment Adjustment for Medicare Disproportionate Share Hospitals for FY 2025.

CMS should pursue policies to modernize DSH calculations in ways that address inequities that many hospitals face. Such efforts could include recommendations to Congress and greater guidance to hospitals given that the Medicare DSH program has become more complicated due to changing patient patterns and continued litigation. Hospitals, particularly those serving rural communities, may see their DSH percentage calculation decline due to several factors outside of their control: the impact of Medicaid redeterminations, a backlog in Social Security disability (SSI) decisions, and a lack of post-acute settings to accept transfers of Medicare beneficiaries. While these factors are often outside of CMS' control too, CMS can work with other agencies such as the Social Security Administration to help hospitals estimate certain factors such as SSI. Given that Medicare DSH is relevant for other federal programs, without clearer guidance at a minimum, hospitals may lose not only DSH payments but also access to other critical public programs.

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

B. Proposed Changes in the Inpatient Hospital Update for FY 2025.

1. Proposed FY 2024 Inpatient Hospital Update.

NRHA thanks CMS for the 2.6% increase in payments to IPPS hospitals but is disappointed to see that rural hospitals will receive an increase closer to 1.9%. This update is inadequate given inflation, workforce shortages, and labor and supply cost pressures that rural hospitals continue to face. Since 2010, over 175 rural hospitals have closed or ceased inpatient services[2] and another 418 additional hospitals are vulnerable to closure.[3] Further, 50% of rural hospitals are operating with negative margins and independent rural hospitals have an average operating margin of -2.2%.[4] Rural hospitals affiliated with a health system are slightly better off with an average operating margin of 1.7%.[5] Losing a hospital is devastating to a rural community as beneficiaries lose a local point of access to care.

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.[6] This would include the IPPS standardized payment amounts. **NRHA urges CMS to consider updating the final payment rate to**

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[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/.

[3] Michael Topchik, et al., *Unrelenting Pressure Pushes Rural Safety Net Crisis into Uncharted Territory*, Chartis (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.

[4] *Id.* at 3.

[5] *Id.*

[6] 42 U.S.C. § 1395ww(d)(5)(I)(i) (2018) ("The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate").

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.** Alternatively, CMS is proposing separate IPPS payments to establish and maintain a buffer stock of essential drugs in this proposed rule. In the past, CMS paid hospitals for their costs associated with procuring NIOSH-approved N95 respirators during the COVID-19 pandemic. NRHA believes that CMS can similarly use this authority to add on payments to rural hospitals that are struggling to operate in the face of inadequate Medicare reimbursement.

2. Extension of Temporary Changes to Low-Volume Hospital Payment Definition and Payment Adjustment Methodology and Conforming Changes to Regulations.

NRHA thanks CMS for extending the Low-Volume Hospital (LVH) payment adjustment in accordance with the Consolidated Appropriations Act (CAA) of 2024 and understands that CMS cannot further extend this payment adjustment without congressional action. See Section E below for NRHA's request on potential extensions of the LVH payment adjustments.

E. Proposed Changes in the Medicare-Dependent, Small Rural Hospital (MDH) Program.

NRHA appreciates CMS' extension of the MDH program consistent with the CAA, 2024 and understands that CMS cannot further extend this program without congressional action. We further thank CMS for its previous policy changes that would allow MDHs to apply for Sole Community Hospital (SCH) status if the MDH designation lapses in January 2025 absent congressional action. NRHA asks that CMS clearly communicate this option to rural hospitals in the event the designation lapses.

NRHA is working with rural health advocates in Congress to ensure a longer-term extension of both MDH and LVH designations beyond the end of 2024 to provide stability and certainty to rural hospitals and CMS in its administration of these programs. In the event that Congress passes an extension after December 31, 2024, **NRHA asks that CMS prepare to retroactively address the time period between expiration of the MDH designation as well as LVH payment adjustment mentioned above and act quickly to restore payments.**

F. Payment for Indirect and Direct Graduate Medical Education Costs.

2. Distribution of Additional Residency Positions Under the Provisions of Section 4122 of Subtitle C of the Consolidated Appropriations Act, 2023 (CAA, 2023).

The CAA, 2023 created 200 new Medicare-funded Graduate Medical Education (GME) slots (Sec. 4122 slots) to allow existing residency programs to expand their training. Similar to the 1,000 new GME slots created in Sec. 126 of the CAA, 2021, Congress identified four categories of eligible hospitals and legislated that 10% of slots go to hospitals in each of the following four categories:

- Hospitals in a rural area or being treated as being rural under § 1886(D)(8)(E) of the Social Security Act;
- Hospitals training over their Medicare cap;
- Hospitals located in a state with a new medical school or new branch campus; and
- Hospitals serving HPSAs.

Two provisions set the Sec. 4122 slots apart from the previous 1,000 new slots. First, Congress mandated that the slots be distributed on a pro rata basis, meaning that each qualifying hospital that submits a timely application would receive at least one fraction of a slot. Second, 100 of the 200 slots must go to psychiatry or psychiatry sub-specialty programs to help alleviate the persistent shortage of behavioral health professionals.

Distributing the new Sec. 4122 slots similar to Sec. 126 will continue to disadvantage rural hospitals and fail to expand rural training opportunities. As discussed in more detail below, prioritizing slot distributions based on HPSA score cuts out some rural hospitals that are ready and able to grow their residency programs. We encourage CMS to consider how to incentivize rural hospitals to apply for the Sec. 4122 opportunity and award slots that will increase rural training.

b.1. Determination That a Hospital Has a "Demonstrated Likelihood" of Filling the Positions.

CAA, 2023 mandates that the Secretary take into account a hospital's "demonstrated likelihood" of filling the new positions, or slots, that they receive within 5 years. CMS interprets this requirement to mean that a hospital should demonstrate that it does not have sufficient room under its current FTE cap to accommodate additional positions or a new planned program. Hospitals meet this by showing that they do not have sufficient room under their FTE resident cap, are not a rural hospital eligible for a cap increase, and intend to use the slots as part of a new residency program. Alternatively, hospitals may meet this by showing that they intend to use the additional slots to expand an existing program and do not have sufficient room under their current cap.

NRHA is concerned that this approach will not benefit rural programs. Large academic medical centers generally have more resources and are better funded, thus they are able to take on additional residents above their Medicare FTE cap. Rural hospitals are unlikely to be able to take on residents that are not funded through Medicare GME. As a result, rural hospitals will be disadvantaged because they will not be seen as "likely to fill" since most rural hospitals are not training above their cap due to limited resources.

c.2. Pro Rata Distribution and Limitation on Individual Hospitals.

NRHA acknowledges that the pro rata distribution is a statutory mandate to which CMS must adhere. Nonetheless, NRHA is extremely concerned that this distribution will discourage rural residency programs from applying. Unfortunately, NRHA members have expressed that they are already deterred from applying for Sec. 126 slots because of the prioritization based on HPSA scores. A disadvantageous pro rata distribution will add yet another barrier to applying. Some rural hospitals may not apply because they may not receive a full slot, or a full FTE. One slot, or one FTE, covers the cost of training one resident for one year. Thus, a fraction of an FTE is not incentive enough for rural residency programs to apply because most of the resident's training would not be funded through

Medicare. Rural residency programs are less able to shoulder unfunded training compared to large urban academic medical centers. This makes CMS' decision on how to administer the pro rata distribution paramount.

CMS proposes two options for pro rata distribution, described below. NRHA does not believe either option will benefit the expansion of rural residency programs but suggests that CMS pursue the second option to ensure rural hospitals have a better chance of receiving new positions.

1. **Prorate all available slots among all qualifying hospitals such that each may receive up to 1 FTE or a fraction of 1 FTE.** For example, if exactly 200 qualifying hospitals applied, each hospital would get 1 FTE. If 350 hospitals applied, each hospital would get 0.57 FTE. If slots remain, they would be distributed based on HPSA scores.
2. **Award each qualifying hospital 0.01 FTE.** For example, if 1,000 qualifying hospitals applied, each would receive 0.01, resulting in the distribution of 10 slots. (1,000 x 0.01 = 10). If slots remain, they would be distributed based on HPSA scores.

NRHA believes that the second option would be most beneficial for growing rural residency programs. If a high number of hospitals apply, there would be more slots leftover to be distributed to each of the four categories, prioritized by HPSA score (discussed below), compared to under the first method. This distribution method leaves the option for rural hospitals to receive multiple slots. In contrast, the first method would make it less likely that rural hospitals would receive more than 1 FTE if 200 or more hospitals apply. In the first round of Sec. 126 distribution 291 hospitals applied for slots. Using this precedent, Sec. 4122 distribution would be more favorable to rural hospitals, who likely need to receive 3 – 5 slots (depending on the specialty) to fully fund a resident for the entire residency.[7] If the first method was used for 291 hospitals, each qualifying hospital would receive about 0.68 FTE and there would be no remaining slots for distribution.

c.3. Prioritization of Applications by HPSA score.

CMS proposes to prioritize applications, following the pro rata distribution, based on HPSA scores. Hospitals serving a population or geographic area with a higher HPSA score will be prioritized, as in Sec. 126 distributions. NRHA notes that this is not a statutory mandate and CMS has the authority to prioritize applications in any way that it sees fit. **NRHA urges CMS to reconsider using HPSA scores alone to identify which hospitals receive the remaining slots after pro rata distribution.**

During the first two rounds of Sec. 126 slot distributions, only 7 geographically rural hospitals received slots. NRHA acknowledges that several factors play into the dearth of slots given to geographically rural hospitals in the first two rounds of Sec. 126 distributions. Nonetheless, high HPSA scores serve as a barrier to entry for rural hospitals seeking slots because HPSA scores often do not prioritize or accurately reflect the needs of areas with small populations. Three primary factors are used in scoring criteria across primary care, mental health, and dental HPSAs: population-to-provider ratio; poverty rates; and travel distance or time to the nearest accessible source of care. There is no measure to account for rurality or unique access problems associated with rural areas.

[7] 291 hospitals x 0.01 = 2.91 slots, or FTEs, distributed among all qualifying hospitals. This leaves about 197 FTEs available to be distributed.

In addition, current HPSA scoring considers very limited population health measures that are not reflective of rural populations, such as low birthweight rate and infant mortality rate. These measures are proxies for understanding the needs of a high utilization population and their related risk factors. However, the higher utilization of services by older adult populations in rural areas and their related risk factors are not accounted for in the current HPSA scoring methodology. On average, rural populations are older than their urban counterparts, and as a result, they have a greater need for access to health care. While the mental health HPSA criteria includes a factor to account for elderly populations ("ratios of the population under the age of 18 and over the age of 65 to the adult population ages 18 to 64"), the primary care HPSA scoring heavily benefits urban populations.

d. Distributing at Least 10 Percent of Positions to Each of the Four Categories.

CMS' distribution of the remaining Sec. 126 slots is not projected to meet the 10% statutory threshold for slots awarded to hospitals serving a geographic HPSA. This is likely due to CMS prioritizing applications based on both population and geographic HPSA scores. In many cases it is easier to achieve a higher population HPSA score compared to a geographic HPSA score, therefore hospitals with a high HPSA score that have received slots are not serving a geographic HPSA because of how CMS is prioritizing applications. With this lesson learned in mind, **NRHA emphasizes the need to find another prioritization metric to avoid the maldistribution between categories of hospitals when distributing Sec. 4122 slots.**

NRHA understands that both the CAA, 2021 and CAA, 2023 allow hospitals "treated as being rural" to qualify for the 10% of slots set aside for rural hospitals. CMS states that it is on track to meet the distribution threshold for the rural category. However, **NRHA flags that 7 geographically rural hospitals have received slots in the first two rounds of distribution.** In the second round, **only 3 programs that received slots trained for more than 50% of the time** in a CMS or Federal Office of Rural Health Policy designated rural area.[8] These two programs include 2 geographically rural hospitals and 1 urban hospital serving as an urban partner in a Rural Track Program.[9] This analysis implies that **reclassified hospitals are making up the bulk of those that receive slots set aside for rural hospitals.** NRHA believes that limiting the rural set aside to geographically rural hospitals would align with the legislative intent of Sec. 126 and we are committed to working with Congress and CMS on ensuring that rural hospitals receive future slots.

3. Proposed Modifications to the Criteria for New Residency Programs and Requests for Information.

CMS proposes changes to how it defines a "new residency program." Historical policy decisions have led to CMS stating that it is necessary to clarify what constitutes a "new" program, namely the ability for urban hospitals to reclassify to rural for IPPS payment purposes.[10] One benefit of reclassifying to rural is that a hospital starting a new program will receive IME payments. In contrast, an urban

[8] Lori Rodefeld, Mukesh Adhikari, & Emily Hawes, *Overview of Residency Programs Selected for CAA Sec. 126 Round Two Graduate Medical Education Slots*, RURAL RESIDENCY PLANNING AND DEVELOPMENT TECHNICAL ASSISTANCE CENTER, 2 (Dec. 2023), https://www.ruralgme.org/research/22/download; FORHP rural is defined as all nonmetropolitan counties, outlying metropolitan counties with no urban population of 50,000 or more, census tracts in metropolitan counties with RUCA codes 4-10, and census tracts in metro counties of at least 400 square miles in area with population density of 35 or less per square mile with RUCA codes 2-3.
[9] *Id.*
[10] 42 U.S.C. § 1395ww(D)(8)(E) (2022) and 42 C.F.R. § 412.103 (2023).

hospital that starts a new residency program cannot receive DGME or IME because of caps in place since 1996. With the proliferation of reclassified hospitals in recent years, urban-located hospitals classified as rural have been eligible for IME payments.

The intent of allowing new rural programs to receive DGME and IME payments was to increase rurally based physician training and grow the rural workforce. Yet workarounds by urban hospitals have diminished this intent and now CMS is considering how to define a "new program" more strictly and thus control the growth of IME payments.

a. Newness of Residents.

Historically, CMS has required that new programs need (1) a separate program director (PD), (2) separate faculty not listed as core faculty for another program in the same specialty, and (3) separately recruited residents. CMS proposes to interpret criterion (3) to mean that 90% of individual residents must not have previous training in the same specialty as the new program. CMS does not have a proposal for PD or faculty.

CMS acknowledges the potential issues with using the 90% threshold for small or rural programs and is soliciting comments on how to define a small program and what approach to use for a small program. CMS suggests defining a small program as 16 or fewer residents. **NRHA agrees with this approach as it meets the minimum number of residents required by ACGME for most specialties.** However, we urge CMS to refine the application of this definition by requiring that the program train residents for more than half of the time in a geographically rural location. Oftentimes certain specialties have small programs, like plastic surgery, but train in urban settings that are not challenged by the same recruitment or resource constraints as small, rural programs.

NRHA urges CMS to exempt small and rural programs from the 90% threshold. Small, rural programs have unique challenges associated with starting a new residency program. New rural programs often matriculate residents from various sources, including transfers from other programs in the same specialty. For example, rural track programs (RTPs) will take second- or third-year residents to ensure there are more senior residents to jumpstart the program. For a small program 3-year program with a resident in each year, two upper-level transfers would mean only 33% of residents are "new." Even a program with 6 residents, one of which transferred from another program, would be disqualified from being considered "new." **If CMS defines a small program, it should be for the purposes of exempting such program from the "new program" definitions.**

b. Newness of Faculty and Program Director – RFI.

CMS is soliciting information on the threshold for faculty with no previous teaching experience in a program of the same specialty. For this criterion, a small program should be defined the same as for the "new resident" factor, i.e., 16 residents or less. **We encourage CMS to exempt small programs and programs that primarily train in a geographically rural area from any new faculty standards.** In addition, **ACGME already regulates the issue of experienced teaching staff in a residency program and NRHA does not believe CMS should interfere in this space.** Most rural

programs, even if they are not considered "small," face faculty recruitment challenges.[11] New small and rural programs often recruit from other programs to ensure their faculty have the requisite experience to precept.

In addition, CMS is soliciting responses on whether thresholds should apply to core faculty only or non-core faculty as well. CMS is also seeking information on whether faculty with 5- or 10-year breaks in teaching should be considered new. Again, we suggest CMS exempt small programs from any faculty threshold for determining whether a program is new. Nonetheless, **NRHA emphasizes again that CMS should not set standards for faculty experience as ACGME regulates this area.** Additionally, very few, if any, faculty would meet the 5- or 10-year period teaching hiatus.

CMS should also exempt small and rural programs from any "new" PD criteria. If CMS moves forward with new standards, **NRHA suggests that CMS align them with ACGME standards.** CMS should not go beyond the standard accreditation requirements. Under ACGME guidelines, all specialties require some combination of three years of educational and/or administrative experience before becoming a PD. **The accrediting body should be the decisionmaker when it comes to new PDs.**

The limited pool of physicians that are qualified to serve as PD is even smaller than that of faculty and experienced PDs are the strongest and most desirable candidates. Additionally, for many small and rural programs like RTPs, the best person for the role is typically the existing urban PD while the local rural site director learns the role under their guidance. The site director then assumes the position of PD. This practice is within the ACGME expectations of new PDs having three years of experience in administration before taking on a PD role.

d. One Hospital Sponsoring Two Programs in the Same Specialty—RFI.

CMS is asking whether it is permissible for one hospital to operate two residency programs in the same specialty and why hospitals may want to do this.

There are several reasons why a hospital may want to sponsor two programs in the same specialty. Hospitals that serve large geographic regions may operate two programs that serve different locations. Relatedly, a hospital may run two programs in the same specialty with significantly different curricula (urban-focused vs. rural or underserved focused). In terms of RTPs, a hospital may sponsor one or more separately accredited RTP that have different missions and curricula for training compared to the core program.

Considering the various circumstances in which a hospital has legitimate reasons to sponsor more than one program in the same specialty, **decisions around whether a hospital sponsoring two programs in the same specialty is acceptable should be left to ACGME.**

IX. Proposed Quality Data Reporting Requirements for Specific Providers.

C. Requirements for and Changes to the Hospital Inpatient Quality Reporting (IQR) Program

[11] Patterson, Schmitz, & Longenecker, *Family Medicine Rural Training Track Residencies: Risks and Resilience*, 51 FAMILY MEDICINE 649, 650-651, (2019), https://journals.stfm.org/media/2569/patterson-2018-0532.pdf.

5. Proposed New Measures for the Hospital IQR Program Measure Set.

a. Proposal to Adopt the Age Friendly Hospital Measure Beginning With the CY 2025 Reporting Period/FY 2027 Payment Determination.

NRHA appreciates CMS' commitment to improving outcomes for older Americans. Rural populations tend to be older than urban populations[12] and this trend will likely continue as the overall U.S. population rapidly ages.[13] As such, NRHA agrees that focusing on optimizing care for older adults is an important goal for rural 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.[14] **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.

The proposed measure addresses a current gap in the IQR Program, and NRHA supports its implementation. Attestation-based measures are typically less onerous than others, with the main burden being staff assessment as to whether a hospital is performing each activity listed in the measure. During the FY 2024 IPPS rulemaking cycle, CMS solicited feedback on two potential future geriatric care structural measures. NRHA's primary feedback was that the two measures were duplicative and thus administratively burdensome and should be combined into one measure if proposed in a future rulemaking cycle.[15] NRHA is pleased to see that CMS is proposing one measure that captures most of the elements described in the FY 2024 proposed rule. Further, last year, NRHA had concerns around the potential for a publicly reported age friendly hospital designation based upon a hospital's attestation on the two potential geriatric care measures. NRHA applauds CMS' decision not to move forward with a publicly reported measure given that various factors, like workforce shortages, may prevent a rural hospital from positively attesting to the elements of the age friendly measure and subsequently receiving the designation.

J. Separate IPPS Payment for Establishing and Maintaining Access to Essential Medicines.

CMS is proposing to establish a separate payment to small, independent hospitals to cover the estimated costs of voluntarily establishing and maintaining a 6-month buffer stock of essential medicines. In the face of recent drug shortages, NRHA supports this proposal and CMS' aim to help

[12] 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/.

[13] 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.

[14] 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.

[15] https://www.ruralhealth.us/getmedia/b6cf8d5a-704f-4f4d-80be-645a8fcc7ad6/FY24-IPPS-proposed-rule-comment-6-9-23.pdf#page=7.

small, rural hospitals. NRHA suggests that CMS improve upon its proposal by including part of the cost of the actual drugs to be included in the separate payment. As proposed, CMS would pay small hospitals for additional reasonable costs related to establishing and maintaining access to a buffer stock of essential medicines, whether procured directly or through a contractual arrangement. The resource costs, while a burden to small rural hospitals, do not represent the entire financial burden of maintaining such a stock.

X. Other Provisions Included in This Proposed Rule.

A. Proposed Transforming Episode Accountability Model (TEAM)

2. Proposed Transforming Episode Accountability Model (TEAM)— Introduction.

CMS is proposing a new mandatory episode-based payment model, TEAM. This model would operate for 5 years and evaluate whether episode-based payment linked with quality measure performance would reduce Medicare spending and improve quality of care. TEAM would test five surgical episodes. Participants would be chosen based on their location in a selected core-based statistical area (CBSA).

3. Provisions of Proposed Transforming Episode Accountability Model.

CMS is interested in testing mandatory episode-based payment in selected geographic areas. CMS chose a mandatory model to ensure meaningful evaluation findings and to include rural and underserved areas, which are often underrepresented in voluntary models. CMS also notes that they specifically want rural hospitals to participate. NRHA appreciates the consideration given to rural hospital participation.

CMS proposes choosing participants based on their location in a selected geographic area. The selected geographic areas are CBSAs, which are made up of Metropolitan Statistical Areas (MSAs) and Micropolitan Statistical Areas (mSAs). CBSAs consist of a county or counties associated with one core area of at least 10,000 people and adjacent counties with a high degree of integration. Ultimately, this brings in some rural hospitals.

In NRHA's response to CMS' episode-based payment model RFI, we noted that CMS must integrate rural providers into all value-based care models moving forward.[16] However, we generally support inclusion where participation is voluntary. **NRHA does not believe rural hospitals should be mandated to participate in an accountable care model at this point given rural provider readiness.** NRHA supports CMS' goal to have all Traditional Medicare beneficiaries in an accountable care relationship by 2030 and believes that rural providers must be thoughtfully included in models to make this goal a reality. Unfortunately, there are numerous rural providers that are not equipped to participate in value-based care yet, even with support. As such, **mandatory models are not appropriate for rural providers at this point and CMS must allow rural hospitals to opt out of TEAM if they are chosen.**

[16] https://www.ruralhealth.us/getmedia/dee62319-2640-4324-ada9-5ea5d1827c5e/NRHA-Episode-Based-Payment-Model-RFI-8-17-2023.pdf.

Mandating rural hospitals participation is problematic because of the unique characteristics of these hospitals. First, rural hospitals generally have lower patient volumes due to geographic spread. In some cases, this is a barrier to participation in value-based care initiatives, like accountable care organizations. However, the opposite is true here. CMS would require rural hospitals with low patient volumes to participate in TEAM. Lower patient volumes lead to another rural issue, which is inadequate financial stability and reserves required for risk assumption. Lower patient volumes mean less reimbursement in a fee-for-service system and therefore less financial resources to manage participate in a new model. Also, any downside risk associated with a value-based care model is challenging for rural hospitals which are not as risk tolerant as larger, urban hospitals. Generally, rural hospitals are poorly capitalized and underfunded so there are fewer resources to draw upon in a bad year. Rural hospitals also need support and additional resources to support any new data collection and analytics associated with participation.

If CMS moves forward with mandatory participation, **NRHA urges a rural opt out option. Any hospitals located in a rural area, including MDHs, LVHs, and sole community hospitals (SCHs) should be allowed to opt out of participating in TEAM** if they are in a selected CBSA. Given that urban hospitals can reclassify to rural, CMS should define rural as in 42 C.F.R. § 412.64(b)(1) and § 412.103(a)(1) – (2). This would help ensure that geographically urban hospitals, as in those in a truly metropolitan area, are still mandated to participate. However, rural hospitals that reclassify because they are physically located in an MSA, but are actually rural, are able to opt out. For example, an NRHA member hospital in Polk County, Missouri is located in the Springfield MSA. About 170,000 people live in Springfield and only 33,000 live in Polk County. This hospital in Polk County uses urban to rural reclassification to retain SCH status. Given the distance between Polk and Springfield, along with the population of Polk County, Polk is clearly rural but grouped into an MSA. These types of reclassified hospitals should be able to opt out.

To be clear, NRHA supports rural inclusion in TEAM and hopes that any rural hospitals chosen are able to participate; however, the option to abstain from the model must be available to these rural hospitals. NRHA suggests that CMS allow hospitals to opt out based on their rural location, defined above, or designation as an MDH, LVH, or SCH.

NRHA stresses that episode-based models must accommodate various levels of familiarity with or ability to assume financial risk in our episode-based RFI response.[17] **We are pleased to see that CMS proposes various model participation tracks with consideration given to safety net providers' ability to assume risk.** Namely, we appreciate the opportunity for rural hospitals to stay in Track 2 for program years 2 – 5, which has a 10% cap on risk of loss. To improve participation by rural hospitals, **NRHA suggests that CMS expand the opportunity for gains to 20% and retain the 10% risk of loss cap.** We believe that the reward should be higher than the risk for rural safety net hospitals that participate, especially if they are mandated to do so. Rural hospitals are too small to assume risk in the same capacity that a large urban hospital or system can.

D. Request for Information on Obstetrical Services Standards for Hospitals, CAHs, and REHs.

[17] https://www.ruralhealth.us/getmedia/dee62319-2640-4324-ada9-5ea5d1827c5e/NRHA-Episode-Based-Payment-Model-RFI-8-17-2023.pdf.

2. Obstetrical Services COP.

NRHA commends CMS for its continued focus on ending rural maternal health disparities. Between 2011 and 2021, 267 rural hospitals ceased providing OB care, representing 25% of rural America's OB units.[18] 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, OB units are one of the first service lines to be ended.

To help address maternal health outcomes nationwide, CMS plans to propose obstetric services conditions of participation (COPs). NRHA appreciates CMS' goal to improve maternal health outcomes without threatening access to care with future obstetric COPs. CMS is soliciting comments on what should be the overarching requirement, scope, and structure for an obstetrical services COP.

NRHA provides the following comments on CMS' questions:

- **Creating an optional services CoP specific to obstetrical services, similar to the current Optional Services CoPs for Surgical services (42 CFR 482.51), Anesthesia services (42 CFR 482.52), Outpatient services (42 CFR 482.54), or Emergency services (42 CFR 482.55).**

NRHA does not support an optional services COP for rural hospitals providing obstetric services. Given the fragile state of rural hospitals and their OB units, additional regulations will be an added burden and cost that rural hospitals cannot take on. The reality of the costs and staffing make rural OB units with small volumes difficult to operate and as mentioned often lead to closure. NRHA is extremely concerned that obstetric services COPs would have a chilling effect on the OB units that still exist and lead to more closures because hospitals cannot afford to comply. Quality of care must be carefully balanced with access, and when the scale tips in favor of quality at the expense of access, it is our most marginalized populations that suffer. For rural hospitals, the COPs could jeopardize access by closing OB units, entire hospitals, or making hospitals uncompetitive compared to surrounding hospitals. If CoPs are put into place, resources and support must be put into place to support rural facilities.

- **Modelling an OB services CoP after infection prevention and control stewardship program CoPs (42 CFR 482.42). This could include requirements relating to service organization and policies, leadership responsibilities, and application to multi-hospital systems.**

Again, **NRHA does not support an obstetric services COP for rural hospitals, critical access hospitals (CAHs), and rural emergency hospitals (REHs).** Mandating one-size-fits-all hospital policies, organization, leadership, and so on for obstetric services will harm rural hospitals. Again, if a rural hospital cannot comply, they will likely cease providing obstetric care, furthering access issues that are already dire in rural America. Insofar as rural hospitals have these policies in place, NRHA is

[18] 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.

supportive and encourages these practices, but it should not be required through COPs. NRHA asks that CMS devote resources towards technical assistance for hospitals that want to comply but do not have the necessary resources. For example, rural hospitals would benefit from templates and other model resources put out by CMS.

- **How would an obstetrical services CoP impact access to care for pregnant, birthing, and postpartum individuals? How will the CoP impact hospitals with respect to factors that have led some facilities to close their maternity units, including high costs, labor shortages, and declining birth rates?**

NRHA warns CMS that imposing one-size-fits-all COPs on rural hospitals will lead to further rural OB unit closures. Nearly one quarter of all OB units closed between 2011 and 2021 and 63 of the closures happened in the span of two years (2020 and 2021).[19] Of the rural hospitals that closed their OB units, 80% were operating with negative margins during the year in which they ceased providing OB services.[20] Again, rural hospitals cut service lines in order to stay financially viable before making the difficult decision to close the hospital entirely. New regulatory burdens will accelerate the trend of rural OB closures.

Statistics around rural OB access is alarming. Nearly 100 communities that lost OB units between 2011 and 2021 have an additional drive time of 30 to 45 minutes.[21] Approximately half of those communities have an added drive time of 45 minutes or more.[22] As expecting rural mothers are forced to travel further for OB care, the risk to mother and baby increases, especially in the event of an emergency.[23] CMS must consider implications of access for individuals living in rural areas when considering any additional requirement related to OB services.

- **What should minimum oversight requirements be for an obstetrical unit?**

There are existing COPs and regulations around supervision and staffing for hospitals. **CMS should not add new staffing requirements on already stressed rural hospitals.** High costs associated with staffing obstetric units in rural hospitals also contributes to financial instability. In particular, CMS designed CAH and most recently REH COPs with the workforce challenges in rural areas in mind. It would be inappropriate to create new staffing standards for CAHs and REHs when they are subject to less stringent requirements. For example, CAHs and REHs must have a health care professional staff that includes at least one physician and may include nurse practitioners, physician assistants, or clinical nurse specialists.[24] For REHs specifically, an RN, CNS, or LPN must be on duty when there is a patient receiving emergency or observation care.[25] Otherwise, the staff must be "sufficient to provide the services essential to the operation of the REH."[26] CAHs must meet similar COPs.[27] Going beyond

[19] *Id.*
[20] *Id.* at 4.
[21] *Id.* at 5.
[22] *Id.*
[23] *Id.*
[24] 42 C.F.R. § 485.28(b); 42 C.F.R. § 485.631(a).
[25] § 485.28(b).
[26] *Id.*
[27] § 485.631(a)(3)-(4).

these standards for a CAH or REH for one particular unit would be incongruous with the rationale behind established staffing standards and would be unworkable for workforce challenged facilities. In particular, each individual CAH and REH understand what is "sufficient to provide essential services" in their facilities and CMS should not step in to tell hospitals what is sufficient from the federal level.

Further, many rural areas have a shortage of providers with advanced training in maternity care, meaning different staffing models are used for maternity services in rural communities. xix Staffing models for maternity care in rural areas vary, with OB services most commonly provided by family practice physicians.[28] A decline in the number of family physicians providing obstetric services is occurring in urban and rural areas across the country due to changes in hospital staffing patterns, malpractice insurance costs, and low Medicaid reimbursement rates, among other factors.[29,30] Recent interviews with rural hospitals in nine states revealed that hospitals with lower birth volume were more likely to have family physicians and general surgeons attending deliveries compared with hospitals with high birth volume, which more frequently had specialized providers like OBs and midwives attending deliveries. The low number of births in rural hospitals makes employing specialty providers such as anesthesiologists challenging. Certified registered nurse anesthetists (CRNA) provide most anesthesia services in rural facilities, but there is significant variation in practice authorities across the country.[31] A rural setting may not have a high enough volume of births to maintain a full-time team of single specialty nurses trained in labor and delivery. Therefore, general nurses are more often used in rural settings.[32]

- **Should obstetrical units be required to maintain a minimum set of obstetrical care equipment and supplies? Should hospitals and CAHs without obstetrical units, emergency departments, and REHs have similar requirements?**

NRHA supports the concept of OB readiness, especially in hospitals without OB units. However, requiring rural hospitals to maintain a minimum set of obstetrical care equipment and supplies cannot be an unfunded mandate. A rural hospital that does not operate an OB unit likely does not have the right patient population to justify an OB unit or closed the unit due to financial challenges. In the latter scenario, it is unlikely that a rural hospital would be able to afford new obstetrical equipment and supplies that they do not have on hand already in order to meet a COP.

Again, NRHA asks that CMS provide resources, like technical assistance, to help rural hospitals achieve this goal. For example, NRHA supports S. 4079/H.R. 8383, the Rural Obstetric Readiness Act.[33] This bill would help prepare rural hospitals and providers to handle the obstetric emergencies that

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[28] C. Brigance, et al., *Nowhere to Go: Maternity Care Deserts Across the U.S.*, MARCH OF DIMES, 2022, https://www.marchofdimes.org/sites/default/files/2022-10/2022_Maternity_Care_Report.pdf.
[29] *Id.*
[30] Brittni Frederiksen, et al., *A National Survey of OBGYNs' Experiences After Dobbs*, KAISER FAMILY FOUNDATION. June 21, 2023, https://www.kff.org/report-section/a-national-survey-of-obgyns-experiences-after-dobbs-report/.
[31] Frank H. Boehm, *Decision to incision: time to reconsider*, 206 AM. J. OBSTETRICS & GYNECOLOGY 97-98 (2011).
[32] Peiyin Hung, et al., *Why Are Obstetric Units in Rural Hospitals Closing Their Doors?*, 51 HEALTH SERVICES RESEARCH 1546, 1547 (2016).
[33] Rural Obstetrics Readiness Act, S. 4079, 118th Cong. (2024) https://www.congress.gov/bill/118th-congress/senate-bill/4079.

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.

- **Are there refinements to Medicare and/or Medicaid payment structures for obstetrics care, and/or perinatal care that could improve the delivery of maternal care, and also address existing disparities? We are interested in specific refinements that are within CMS statutory authorities.**

Financial challenges, such as low Medicaid reimbursement rates and high costs of malpractice insurance, are significant barriers to keeping obstetric units open in rural hospitals.[34] Rural hospitals are more reliant on Medicaid, with nearly half of all births in these facilities covered by Medicaid.[35] The high rate of births covered by Medicaid poses a financial challenge for rural hospitals, as Medicaid reimbursement for childbirth is half the rate of private insurers on average.[36] High costs associated with staffing obstetric units in rural hospitals also contributes to financial instability. While many hospitals rely on elective surgeries and other services to assist in subsidizing financial loss, the resources necessary to conduct these procedures may not be provided in rural communities.[37]

Rural hospitals still providing labor and delivery should receive adequate funding to ensure these services remain viable. NRHA supports expanding Medicaid eligibility for pregnant women by using flexibilities in Medicaid programs to address rural OB service barriers. NRHA supports protections for low-volume providers, liability insurance, and resources to support rural OB services under state Medicaid programs. NRHA also encourages innovation through establishing alternative payment models for obstetrics and delivery. Models of care should include prenatal and postnatal care, as well as behavioral health support services for both substance use and mental health concerns.

3. Staff Training.

- **Should minimum OB staff training requirements (both initial and ongoing) be included in an obstetric services CoP? Given the rate of OB unit closures, should CMS require a minimum obstetrical training standard for hospital/CAH non-OB unit, emergency department, REH, or other non-OB staff that may care for pregnant, birthing, and postpartum patients to improve maternal health outcomes?**

[34] American Hospital Association, Rural Hospital Closures Threaten Access, 2022, https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf
[35] Government Accountability Office, *Maternal health: Availability of hospital-based obstetric care in rural areas*, (Oct. 19, 2022) https://www.gao.gov/products/gao-23-105515
[36] Truven Health Analytics. The Cost of Having a Baby in the United States. 2013. https://www.nationalpartnership.org/ourwork/resources/health-care/maternity/archive/the-cost-of-having-a-baby-in-the-us.pdf
[37] GAO *supra* note 35.

NRHA reiterates that new requirements, like training and maintenance of supplies, cannot be an unfunded mandate on rural hospitals. We believe that proper obstetrical emergency training for providers that are not primarily working in or specialized in obstetrics is important. However, a rural setting may not have a high enough volume of births to maintain a full-time team of single specialty nurses trained in labor and delivery. The low volume of deliveries in rural hospitals may make it difficult for doctors and nurses to maintain related skills.[38] Again, we highlight the need for additional resources and adequate Medicare and Medicaid reimbursement rates for rural hospitals to meet any obstetric training requirements.

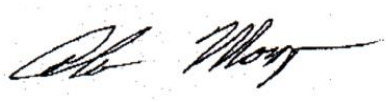
F. CoP Requirements for Hospitals and CAHs To Report Acute Respiratory Illnesses.

4. Soliciting Input on Collecting Data by Race and Ethnicity.

CMS is soliciting comments on whether race and ethnicity demographic information should be explicitly included as part of ongoing requirements for respiratory illness reporting. **NRHA supports reporting this information on a voluntary basis where rural providers have the information and capacity to do so.** NRHA suggests aligning demographic data reporting requirements with current federal initiatives aimed at collecting more comprehensive race and ethnicity data. NRHA has supported OMB's revised policy on maintaining and collecting federal data on race and ethnicity and believes that CMS should align any future reporting with this bulletin.[39]

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,



Alan Morgan
Chief Executive Officer
National Rural Health Association

[38] Hung, et al. *supra* note 32.
[39] Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, 89 Fed. Reg. 22182 (Mar. 29, 2024).