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NATIONAL RURAL HEALTH ASSOCIATION

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Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals.

Dear Administrator Verma,

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 Program; Hospital Inpatient Prospective Payment System (IPPS) and Proposed Policy Changes and Fiscal Year (FY) 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals. We appreciate your continued commitment to the needs of the more than 60 million Americans that reside in rural areas and look forward to our continued collaboration to improve health care access and quality 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.

NRHA is concerned about the proposed changes to the disproportionate share hospitals (DSH) uncompensated care payments (UCP) formula. The proposed 6.4 percent decrease for UCP in FY 2021 will be felt significantly harder in rural America than in their urban

counterparts. According to CMS' calculations, rural hospitals are projected to receive an 11.48 percent decrease in UCP, nearly $60 million. Urban hospitals, on the contrary, are projected to only receive a 6 percent decrease. A greater than 11 percent decrease in UCP for rural America will be hard felt. Since commenting on the FY 2020 IPPS proposal one year ago, we have seen 11 rural hospitals close. The onslaught of COVID-19 is only making a dire situation even worse. Many rural hospitals struggle on a daily basis to remain solvent following previous payment cuts. Negatively changing reimbursement in UCP for rural hospitals only adds to the struggle. Almost half of rural hospitals are currently operating at a loss and this trend does not appear to be changing. Rural hospitals need compensation formulas that will allow them to keep their doors open to help their communities long after COVID-19. If rural hospitals continue to receive formula decreases, like that proposed by CMS in UCP, doors may continue to shutter at an even more alarming rate. NRHA asks that CMS reevaluate the UCP formula to achieve parity between rural and urban payments.

NRHA supports the continued efforts to improve payments for those in the bottom quartile of the wage index. We continue to urge CMS to hold harmless struggling rural and Indian Health Service providers whose wage index has previously been adjusted to better reflect costs and who may be disadvantaged due to this change. The continued effort of CMS to reexamine and adjust the wage index is appreciated. NRHA has an extended history, dating back to the start of our organization, of fighting the wage index inequalities harming rural providers seeking to care for rural Americans. Improving the policy will create greater equity among providers and will significantly help the many struggling rural hospitals who provide care for a disproportionately high number of seniors. Many rural hospitals in low wage index areas struggle on a daily basis to remain solvent following payment cuts and policy changes that have led to the current astounding rate of hospital closures. The onslaught of COVID-19 has only made matters worse. Before the pandemic, more than 47 percent of rural hospitals were operating at a loss and preliminary data shows the trend continuing. Since 2010, 128 rural hospitals have closed. In the one year since commenting on the FY 2020 IPPS proposal, 11 rural hospitals have closed their doors.

Rural communities are greatly affected by the maldistribution of healthcare professionals. Indeed, the Robert Wood Johnson Foundation found that maldistribution was a much larger problem than an absolute shortage of primary care providers. One aspect of this maldistribution is the fact that urban facilities offer better salaries and benefits, plus the additional benefits of greater peer support from a larger workforce. Economic forces would indicate that paying higher, not the lower rates already provided for under the wage index, is the appropriate response to workforce maldistribution. Basic economic principles indicate the rural wage index should exceed that of the urban areas without shortages, instead of a low index based on the cost of living. Indeed the very existence of the wage index is self-perpetuating in that a rural community is provided fewer resources and is thus unable to afford higher wages resulting in either hiring only those that can and will accept lower wages, while also not filling other positions that if filled would potentially lift their wage index. In reality, the market for professional services do not drop abruptly at the county line, instead they change over areas with some professionals traveling from market to market for a variety of reasons including wages. It is expected that some rural areas would share professional marketplaces with neighboring communities that

maybe larger, while still retaining their rural nature. NRHA urges CMS to reconsider the wage index as a tool to reduce maldistribution of health care providers instead of just attempting to focus on the spending power of that money.

Additionally, CMS must ensure that in those rural places where the wage index has made it difficult to recruit and retain a health care workforce are not penalized under this change. NRHA supports a hold harmless provision for rural providers that would be negatively impacted by this change to ensure access in these rural areas is not eroded by this policy.

NRHA supports the goal of interoperability and data sharing with patients. NRHA supports the proposed 90-day reporting period for attestation for the Promoting Interoperability Programs, however we continue to urge the burden fall on the software companies not the small rural hospitals since only the software companies have the power to comply with these regulations. Ensuring the burden be placed on the software companies is even more critical as CMS considers increasing the number of quarters of electronic clinical quality measures (eCQMs) data hospitals must report. Rural hospitals have attempted to make prudent choices in attaining Electronic Health Record (EHR) products. However, many have found themselves needing to purchase new products when the vendor selected to not upgrade the product, leaving some hospitals to have to take the time and expense of setting up and training staff on multiple software programs. Further complicating the use and upgrades required, many rural communities do not have a sufficient IT workforce. CMS' laudable goal of increasing the incoming data from hospitals must be matched with adequate support. Rural hospitals already struggling to provide the data and comply with EHR requirements will need flexibility and support to glide into full compliance. Therefore, NRHA asks for continued flexibility while continuing to move towards the goal of interoperability and urges CMS to consider additional hardship exemptions for small rural providers that find themselves unable to upgrade due to vendor decisions.

NRHA is concerned about the proposal to require hospitals to report median payer-specific negotiated rates for inpatient services, by Medicare Severity-Diagnosis Related Group (MS-DRG), for Medicare Advantage organizations and third-party payers on the Medicare cost report. To accomplish this task, rural hospitals will have to go through the burdensome task of collecting and assembling data, as well as continuing down a track of disclosing to the public privately negotiated contract terms. NRHA is concerned that because there is such a lack of diverse payments in rural communities—only one payer in much of rural America—it is going to be overly burdensome and ultimately cause rural patients to be at a disadvantage. There is no telling the impact of how MS-DRGs will impact the reimbursement of rural facilities. If the methodology produced ultimately underpays rural hospitals due to low-volume and related activity in comparison to their urban counterpart, that could again add to the devastating issue of hospital closures in rural America.

Thank you for the chance to offer comments on this proposed rule and for your consideration on our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care. If you would like additional information, please contact Josh Jorgensen at jjorgensen@nrharural.org or 202-639-0550.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association