

June 16, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G Washington, DC 20201

RE: CMS-1771-P; 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 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation

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) 2023. 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

D.13.d. Request for Information on Social Determinants of Health Diagnosis Codes

NRHA commends CMS for considering social determinants of health in MS-DRG codes. Currently, social determinants of health (SDOH) are voluntarily reported by hospitals in ICD-10-CM categories Z55-65, known as Z codes, representing "[p]ersons with potential health hazards related to socioeconomic and psychosocial circumstances." SDOH are extremely important for historically underserved and under resourced groups, like rural populations. On average, rural Americans are sicker, older, and poorer than their urban counterparts and therefore SDOH are more likely to affect their health outcomes. It is especially important for rural beneficiaries to be represented in data to assess how SDOH play into severity of illness, outcomes, etc.

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However, NRHA is concerned with the potential hospital resource utilization associated with screening and reporting Z codes. For rural hospitals, bandwidth is already low due to workforce shortages and heavy caseloads for each health care worker. Screening and recognition of some SDOH, on top of existing workloads, may require more than a physician or nurse and instead may require engaging a social worker, care coordinator or other individual with specialized training. Social workers or psychologists may not be standard members of care teams at all rural hospitals. Certain Z codes such as death or disappearance of a family member, relationship problems with spouse or partner, social isolation, and lack of adequate food are not readily apparent when working with a patient and require more time, extensive screening, or patient self-reporting to identify.¹ Our members also note that trust is an issue when screening for Z codes as some are deeply personal matters. Rural patients may be less trusting of physicians or nurses and may be more comfortable talking about these issues to certified nurse aides or other aides who then must know to relay this information to the appropriate professional that can code for it. On top of that, Z codes and SDOH may be information that patients are uncomfortable having in their charts.

There are also infrastructure-related barriers to coding for Z codes that CMS must address before requiring widespread reporting. For example, lack of standardized electronic health record screening tools and lack of knowledge among providers and coders were recognized as barriers by CMS in a study on Z code utilization among Medicare beneficiaries.² Consistently, our members have voiced concerns that their technology may not support Z code utilization and may take additional administrative support to transition information between notes, charts, and coding of services.

For CMS to mandate reporting of certain Z codes, it must provide support and act upon potential barriers to coding. For example, CMS should provide resources and technical assistance for providers to learn to code Z codes and to integrate Z codes into their existing technology if possible. CMS should also provide educational resources for hospitals to use with nurses and aides on the importance of SDOH in chart review and note taking so that appropriate factors can be coded. Rural hospitals want to be able to use Z codes as they can be critical to the integration of services, like SDOH, but need more support in terms of education and financial resources from CMS in order to do so.

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

N. Proposed Permanent Cap on Wage Index Decreases

NRHA is pleased to see that the agency has proposed a 5% cap on any decrease to a hospital's wage index. External factors outside of a hospital's control, such as COVID-19, can contribute to significant fluctuations in the wage index, and a cap on any decrease will mitigate those factors

¹ CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries, 2019* (Sept. 2021), Appendix Table 1A
<https://www.cms.gov/files/document/z-codes-data-highlight.pdf>.

² *Id.* at 1.

However, NRHA urges that this cap be applied in a non-budget neutral way for rural hospitals. There is substantial variation in the hospital wage index adjustment of rural and urban hospitals,³ which CMS recognized in its FY 2020 IPPS Final Rule stating “the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure.”⁴ Given that all hospitals are affected by the budget neutrality to offset changes in wage index, hospitals receiving a cap will receive a benefit, but non-protected hospitals may receive a detriment if not implemented in an appropriate manner.

IV. Proposed Payment Adjustment for Medicare Disproportionate Share Hospitals (DSHs) for FY 2023

NRHA is concerned about the \$654 million decrease in DSH funding for FY 2023. A number of rural hospitals rely greatly upon DSH payments and cannot sustain another payment decrease, notably in light of the \$4 billion reduction in DSH allotments in FY 2020. The decrease proposed in this rule would be the third consecutive year of payment cuts to DSH hospitals. Rural hospitals that receive DSH payments are likely to feel greater effects from the payment decrease than their counterparts, which compounds the already precarious financial situation they are in due to the COVID-19 pandemic.

Additionally, as part of the calculation of uncompensated care payments for DSH, CMS projects that the uninsured rate will decrease from FY 2022 to FY 2023. However, we are skeptical of this as there are estimates that at least five million people will lose Medicaid coverage when the continuous enrollment requirement ends along with the PHE.⁵ When the PHE ends in FY 2023, we will likely see a substantial increase in the number of uninsured people. NRHA is concerned that those numbers will not be reflected or accounted for in the DSH uncompensated care payment calculation.

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

A.1. Proposed FY 2023 Inpatient Hospital Update

NRHA has significant concerns about the low amount of the payment updates, particularly given the inflationary environment and continued labor and supply cost pressures that

³ G. Mark Holmes, Kristie W. Thompson, and George H. Pink, *A Rural Urban Comparison of the Proposed 2020 Wage Index*, NORTH CAROLINA RURAL HEALTH RESEARCH CENTER, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA CHAPEL HILL (June 2019), 9 https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2019/06/Wage-Index-Quartile-Proposal.pdf.

⁴ Medicare Program Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2020 Rates. 84 Fed. Reg. 42326 (Aug. 16, 2019) (codified at 42 C.F.R. pts. 412, 413, 495).

⁵ Elizabeth Williams, Robin Rudowitz, and Bradley Corallo, *Fiscal and Enrollment Implications of Medicaid Continuous Coverage Requirement During and After the PHE Ends*, KAISER FAMILY FOUNDATION (May 10, 2022), <https://www.kff.org/medicaid/issue-brief/fiscal-and-enrollment-implications-of-medicare-continuous-coverage-requirement-during-and-after-the-phe-ends/>.

hospitals and health systems face. NRHA is troubled by the even lower payment updates rural PPS hospital, specifically, facilities with 0-49 beds and 50-99 beds increases of 2.8% and 2.9% respectively. These updates amount to a net decrease in payments from FY 2022 to 2023 and will have a disproportionate impact on rural hospitals. One analysis estimates that labor costs have gone up 6.5%, meaning that the proposed payment update falls far short of covering rural hospitals' actual costs.⁶ CMS must consider how the challenges associated with hospitals' fight against COVID-19, coupled with an overall decrease in IPPS payments, will harm rural hospitals.

Since 2010, 138 rural hospitals have ceased operation, and another 453 are vulnerable to closure.⁷ While government intervention in the form of pandemic relief funds temporarily stabilized rural hospitals, the end of those funds coupled with increased labor costs, high inflation rates, and the statutorily required Medicare sequestration and Pay-As-You-Go (PAYGO) policies could be disastrous. To mitigate this, CMS must explore pathways to increase the FY 2023 payment update. A decrease in IPPS payments, coupled with the aforementioned challenges means that many rural hospitals will struggle to stay financially viable and keep their doors open as an access point for rural beneficiaries.

NRHA asks that CMS implement a retrospective adjustment for FY 2023 to account for the difference between the market basket update implemented in FY 2022 and what the market basket is currently projected to be for FY 2022. The market basket calculation uses historical data to make future projects, but at this time, historical data is no longer useful for predicting future changes. To illustrate, the FY 2022 market basket is trending toward 4.0%, yet CMS implemented a 2.7% market basket rate in its FY 2022 final rule. This difference must be incorporated into the FY 2023 rate to make the payment more digestible for hospitals.

NRHA also has concerns with the productivity adjustment. This adjustment is meant to align payments with the actual cost of providing care and reflect economy-wide productivity gains. But with high turnover and staffing shortages, increasing labor costs, record-high inflation, and supply chain constraints leading to difficulty acquiring supplies, hospitals are not seeing such productivity gains. **NRHA proposes that CMS eliminate the productivity adjustment for FY 2023.**

C. Proposed Payment Adjustment for Low Volume Hospitals; D. Proposed Changes in the Medicare-Dependent, Small Rural Hospital Program

NRHA acknowledges the position that CMS is in regarding continuing both the low volume hospital (LVH) and Medicare-dependent hospital (MDH) programs. **We are hopeful that Congress will reauthorize the LVH and MDH programs in a potential end of year package. NRHA asks that CMS does its best to quickly extend these designations to the extent it is able if Congress acts.** CMS should prepare to retroactively to address the time period between expiration of LVH and MDH designation programs and their hopeful reauthorization. These designations are critical to

⁶ PREMIER INC., *PINC AI™ Data: CMS Data Underestimates Hospital Labor Spending* (Apr. 12, 2022), <https://premierinc.com/newsroom/blog/pinc-ai-data-cms-data-underestimates-hospital-labor-spending>.

⁷ THE CHARTIS GROUP, *Pandemic Increases Pressure on Rural Hospitals & Communities* (2022), 1 <https://www.chartis.com/sites/default/files/documents/Pandemic%20Increases%20Pressure%20on%20Rural%20Hospitals-Chartis.pdf>.

rural hospitals and allow them to receive additional much-needed funding. NRHA also asks CMS, if Congress does not reauthorize the MDH program, to make it widely known that rural hospitals may apply for sole community hospital status by September 1, 2022, as an alternative channel for funding as appropriate.

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

NRHA supports CMS' proposed change to allow rural and urban hospitals to enter into a Rural Training Track Program (RTP) Medicare Graduate Medical Education (GME) affiliation agreement. This change affords important flexibility to teaching hospitals that cross-train students by sharing RTP slots, and in turn further encourages future physicians to practice in rural settings.

I. Hospital Value-Based Purchasing (VBP) Program: Proposed Policy Changes; J. Hospital-Acquired Conditions Reduction Program: Proposed Updates and Changes

NRHA appreciates CMS' proposal not to penalize providers for non-representative performance under the Hospital-Acquired Condition Reduction and Value-Based Purchasing Programs from FY 2023. This suppression measure will provide important relief for rural providers of compliance concerns during a time of unique challenges due to COVID-19.

IX. Quality Data Reporting Requirements for Specific Providers and Suppliers

A. Current Assessment of Climate Change Impacts on Outcomes, Care, and Health Equity – Request for Information

NRHA commends CMS' recognition of climate change as a public health issue. **CMS can support rural health care providers in preparing for climate change by being mindful of the rural experience.** Rural communities are less adaptable to changing circumstances, such as the effects of climate change, because of more limited internet access, resources, infrastructure, political influence, and economic diversity.⁸ Yet, rural areas may be more vulnerable to the impacts of climate change. In particular, our members have voiced concerns about the increased frequency of natural disasters posing a threat to their communities and their capacity for disaster preparedness. The rural lens is crucial to developing programs and systems to support health care providers facing the effects of climate change.

B. Overarching Principles for Measuring Healthcare Disparities Across CMS Quality Programs – Request for Information

NRHA is supportive of measures that assess and analyze disparities between demographics of beneficiaries. NRHA applauds CMS' proposals to begin collecting data on measures that address access to care and appropriateness of care. These two measures, when evaluated alongside patient outcomes, can create a fuller picture of disparities. These measures are also distinctly

⁸ Prasanna Gowda, et al., *Impacts, Risks, and Adaptation in the United States: Fourth National Climate Assessment, Volume II* Chapter 10: Agriculture and Rural Communities (2018), <https://nca2018.globalchange.gov/chapter/10/>.

important for rural beneficiaries as access and appropriateness of care are two major issues. Rural populations are not a monolith and vary across the country. Some rural populations are at the intersection of several indicators of health disparities – race and ethnicity, income level, plus geographic location. These populations face compounding issues like poverty, language barriers, lack of educational attainment, and low health literacy, all of which add up to poorer health outcomes.⁹ Beginning to track health disparities is an important step towards reaching health equity.

NRHA also encourages CMS to adopt area-based information for indicators of social risk factors for stratification when patient-reported information is not available. Area-based data could generate useful information about typical social risk factors that are present if a patient lives in a particular area. This is very relevant for rural beneficiaries and will help stakeholders understand what social risks are most prevalent in rural areas.

E.5. Hospital Inpatient Quality Reporting Program: New Measures Being Proposed for the Hospital IQR Program Measure Set

NRHA applauds CMS' proposed efforts on new quality reporting measures. Health equity and social drivers of health are pressing issues facing rural communities and NRHA gives thanks to CMS for bringing attention and transparency to these areas. While we echo some of our concerns above (II. D.13.d.) on the potential burden of screening for social drivers of health, we are less troubled as there are a limited set of factors for screening. Maternal health and outcomes, opioid use, and malnutrition are other serious concerns in rural health and NRHA supports CMS bringing them to light through QRP measures.

E.8. Proposed Establishment of a Publicly Reported Hospital Designation To Capture the Quality and Safety of Maternity Care

NRHA is pleased to offer comments on the proposed maternal care and safety designation for hospitals. **NRHA supports HHS and CMS' focus on improving maternal health outcomes and reducing disparities.** We acknowledge the importance of improving quality because, as CMS rightly notes, rural pregnant people are at higher risk for severe maternal morbidity and are more likely to die before, during, or after birth compared to urban pregnant people. Increasing quality is key to changing these statistics for rural individuals.

Unfortunately, rural communities face many barriers to improving maternal health care.¹⁰ Obstetric (OB) units in rural hospitals struggle to stay viable and have been increasingly closing. As of 2018, only 40% of rural counties had a hospital that provided inpatient OB care.¹¹ The most rural counties

⁹ RURAL HEALTH INFORMATION HUB, *Rural Health Disparities* (Apr. 4, 2019), <https://www.ruralhealthinfo.org/topics/rural-health-disparities>.

¹⁰ RURAL HEALTH INFORMATION HUB, *Barriers to Improving Maternal Health* (May 17, 2021), <https://www.ruralhealthinfo.org/toolkits/maternal-health/1/barriers>.

¹¹ Katy B. Kozhimannil, et al., *Rural Hospital Administrators' Beliefs About Safety, Financial Viability, and Community Need for Offering Obstetric Care*, 3 JAMA HEALTH FORUM 2 (2022), <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2790544>.

had the fewest number of hospitals offering OB services and on top of that, felt the largest reduction in OB services.¹² The consequences of losing these services in more remote rural counties included reductions in prenatal care and increases in preterm birth, births in emergency departments, out-of-hospital birth, and cesarean births.¹³ Another barrier to improving maternal health care is the fixed costs associated with staff readiness and training. Fixed costs associated with workforce, coupled with the majority of deliveries being paid by Medicaid, means that most rural hospitals provide these services at a loss.

Conceptually, a new quality designation would improve OB services for pregnant people at hospitals. But NRHA is worried that this designation could create two potential problems for some rural hospitals. First, diversion of resources to implement a Perinatal Quality Collaborative initiative (PQCI), and thus earn the designation may be financially unfeasible for a number of rural hospitals facing OB unit closure. Second, rural hospitals that may not be able to participate in PQCIs, and therefore do not earn the designation, will lose patients to other hospitals that do have the designation, furthering bypass of services by rural pregnant people with means to do so.

In theory a maternal care designation could help to keep births in local, rural hospitals and minimize bypass. However, NRHA is concerned about the subset of small rural hospitals that do not have the resources to put into OB units. Consequently, these rural hospitals may not be able to earn the designation. Therefore, a maternal safety designation may have unintended consequences for some rural hospitals. Bypass is an issue for rural hospitals in which rural residents do not seek care at their closest hospital and choose to travel farther for care. Hospitals are more likely to experience bypass if they are a Critical Access Hospital, smaller, less profitable, and do not provide OB services.¹⁴ If rural hospitals do not earn the designation through participating in PQCIs, pregnant people with the means to travel to a further hospital with a designation, whether rural or urban, will do so. This would inadvertently create bypass, further threatening the viability of OB services in rural areas. This unintended consequence may lead to rural hospitals being discouraged from providing OB services because they cannot afford to compete with other hospitals by achieving the designation.

Such factors may create environments where some rural pregnant people are not receiving necessary access to care. 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 designation could jeopardize access by closing OB units, entire hospitals, or making hospitals uncompetitive compared to surrounding hospitals with the designation. Lowering

¹² Peiyin Hung, et al. *Closure of Hospital Obstetric Services Disproportionately Affects Less-Populated Rural Counties*, UNIVERSITY OF MINNESOTA RURAL HEALTH RESEARCH CENTER (Apr. 2017), 2 https://rhrc.umn.edu/wp-content/files_mf/1491501904UMRHRCOBclosuresPolicyBrief.pdf.

¹³ Kozhimannil, *supra* note 11.

¹⁴ Mark Holmes and Tyler Malone, *Patterns of Hospital Bypass and Inpatient Care-Seeking by Rural Residents*, NORTH CAROLINA RURAL HEALTH RESEARCH PROGRAM, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA CHAPEL HILL (Apr. 2020), 1 https://www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2020/04/Patterns-of-Hospital-Bypass-and-Inpatient-Care-Seeking-by-Rural-Residents.pdf.

access means that individuals without the means to travel to seek care elsewhere will give birth in communities that are not prepared for them.

Rural hospitals cannot achieve a maternal health designation without resources and support. Tacking on a designation program without associated resources does not solve the maternal care problem that exists in rural communities. With proper resources, the designation would be positive for both hospitals and patients by improving access to quality care. Quality of care is extremely important, and NRHA fully supports bettering maternal care for pregnant people. But increasing quality must be done with an eye towards maintaining access for all pregnant people, especially rural people, and a sensitivity to rural hospitals' resource challenges.

NRHA asks that CMS offer resources so that all rural hospitals have an equitable chance of achieving the maternal safety designation. Rural hospitals should be on a level playing field with each other, and with urban hospitals, when it comes to achieving the designation. NRHA wants to ensure that rural hospitals do not appear to provide substandard maternal care when the issue is rather that some hospitals lack the resources to participate in PQCIs.

NRHA suggests that CMS provide incentives for rural hospitals to collaborate with nearby hospitals and share resources, thus allowing such groups of hospitals to become designated collectively. Resource sharing could include knowledge, equipment, best practices, etc. Rural hospitals should be able to collaborate with any nearby hospital – rural or urban – to achieve collective designation. Incentivizing this resource sharing would mitigate possible bypass because it would increase the number of hospitals with a designation, meaning more pregnant people would seek care at their local hospital.

NRHA also implores CMS to expand participation beyond PQCIs. CMS should allow hospitals participating in other statewide maternal health quality activities to be designated. We have heard from members that they are part of other statewide quality activities but may not qualify for the designation because the activities are not PQCI specific. There are also several states with significant rural populations that are still developing PQCIs, including AR, ID, ND, NV, SD, VA, and WY.¹⁵ NRHA believes that it would be inequitable to those states if PQCIs were the only measure applicable to the designation as they would not be able to participate.

NRHA asks that CMS set aside funding for technical assistance. Technical assistance would support facilities that alone are unable to participate in PQCIs. Again, NRHA wants to ensure that hospitals do not miss out on the designation due to lack of resources, thus creating the image that they provide inadequate maternal care. Assistance would fill in gaps, like workforce shortages and training, that would otherwise hinder a hospital from implementing PQCIs. Technical assistance could also guide rural hospitals with the means to participate, but without the technical knowledge of PQCIs or other quality activities.

¹⁵ CENTERS FOR DISEASE CONTROL AND PREVENTION, *State Perinatal Quality Collaboratives* (Apr. 13, 2022), <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html> (The states developing PQCIs are Nevada, Idaho, Wyoming, North Dakota, South Dakota, Arkansas, and Virginia).

Last, NRHA stresses the critical role of data. CMS should promulgate a monitoring program to inform stakeholders on the efficacy of the maternal health designation. Once designations are in place, CMS should monitor the facilities that are earning the designation. This includes monitoring what types of hospitals, geographically, are participating. This information can then inform CMS what additional resources are needed to support facilities that are participating or those that would like to but do not have the capacity. Monitoring should also include which hospitals have not earned the designation, how many OB units have closed, and how access to OB care has changed because of the designation.

X. Changes for Hospitals and Other Providers and Suppliers

B. Condition of Participation (CoP) Requirements for Hospitals and CAHs To Report Data Elements To Address Any Future Pandemics and Epidemics as Determined by the Secretary

The COVID-19 pandemic has been disastrous for the health care industry and rural communities are no exception. While the beginning of the pandemic saw higher confirmed COVID-19 incidences and deaths in metropolitan areas, rural areas soon caught up in the summer of 2020 and continued to lead in late summer 2021 and again during the winter 2021-2022 surge.¹⁶ With this in mind, NRHA appreciates CMS' effort to establish new reporting requirements for future public health emergencies in order to protect patient safety and swiftly respond to future public health crises.

However, NRHA is concerned with rural hospitals' ability to report on these data measures given resource scarcity and workforce challenges. NRHA takes issue with the burdensome reporting requirements – either daily or weekly – depending upon the Secretary's discretion as to the severity of the public health emergency. CMS estimates that daily reporting would require three hours of work by a nurse for a cost of about \$86,505 to each facility. For reporting, this is an exorbitant cost placed upon already financially vulnerable facilities. COVID-19 has revealed that major public health emergencies can wreak havoc on hospitals in many areas, principally in workforce and finances. Potentially requiring onerous daily reporting during a time where staff and money are being stretched farther than usual is not practical.

Rural hospitals in particular need resources to go along with demanding reporting requirements. CMS also estimates that weekly reporting would require one and a half hours of labor and cost facilities each about \$6,162. **NRHA agrees that data during an epidemic or pandemic is essential, especially in hospitals, yet NRHA advises CMS against mandating expensive and time-consuming daily reporting without providing resources.** Implementing weekly reporting would be more feasible for rural hospitals. If daily reporting is adopted, **NRHA requests that resources are available for small and rural hospitals in order to comply. Technical assistance and other resources would ease the burdens on our hospitals.**

¹⁶ Fred Ullrich and Keith Miller, *COVID-19 Cases and Deaths, Metropolitan and Nonmetropolitan Counties Over Time*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS (May 2022), 1 <https://rupri.public-health.uiowa.edu/publications/policybriefs/2020/COVID%20Longitudinal%20Data.pdf>.



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. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us or 202-639-0550.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light gray dotted grid background.

Alan Morgan
Chief Executive Officer
National Rural Health Association