ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

September 13, 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, D.C. 20201

RE: CMS-1772-P: Medicare Program: Rural Emergency Hospitals: Quality Reporting Program, Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral

Dear Administrator Brooks-LaSure:

The Alaska Hospital and Healthcare Association (AHHA) appreciates the opportunity to provide comments on the provisions of the 2023 Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Proposed Rule (Proposed Rule) regarding the Rural Emergency Hospital (REH) Program.

AHHA is a membership organization representing Alaska's hospitals, nursing homes, home health / hospice agencies, and other healthcare partners. Our mission is to advance the shared interests of the healthcare industry to build an innovative, sustainable system of care for all Alaskans. We represent over 65 health care organizations in Alaska including fifteen rural and critical access hospitals (CAHs) who are potentially eligible for the REH program. Ensuring all communities have access to high quality health care is a top priority for our association. We believe a specific emphasis must be paid to the challenges of ensuring access to care in rural communities.

Alaska is exceptionally rural. Alaska's small and rural hospitals provide essential health care services to most of the state outside of the Anchorage/Fairbanks rail belt. These hospitals are cornerstones of the communities they serve. Thirteen of Alaska's rural hospitals are Critical Access Hospitals (CAH) including six tribally operated CAHs. Most Alaska CAHs have co-located nursing home (long-term) beds, which are primarily paid for by Medicaid.

Following publication of the Proposed Rule, AHHA carefully analyzed the provisions regarding the REH quality reporting program, REH fee-for-service reimbursement, the monthly facility payment, and the enrollment process. The comments developed provide CMS with the perspective of Alaska hospitals who would be implementing the REH Program in their communities to maintain access to high quality healthcare services.

I. REH Quality Reporting Program

AHHA urges CMS to focus exclusively on identifying the most appropriate measure or measures for the launch of the REH Quality Reporting Program, as opposed to considering measures which

may be added as the REH Program matures. Proposed measures should be evaluated using the following criteria: (1) Would a facility converting to an REH have established processes in place to collect data required for the measure? (2) Is the measure outcome likely to be influenced by factors beyond the REH's control? (3) Does the measure provide data to drive performance improvement initiatives? (4) If the measure pertains to a specific condition or procedure, is it likely the REH will have a sufficient volume of cases to provide meaningful results?

AHHA agrees with the National Advisory Committee on Rural Health and Human Services' recommendation to include the MBQIP measure for Emergency Department Transfer Communication (EDTC), as it meets each of the criteria. Most CAHs have established processes to complete required chart abstractions, report results, and develop and implement performance improvement initiatives based on their results. Although these processes are time consuming, CAHs report the EDTC measure is well-defined and relevant to their operations (i.e., not impacted by factors outside the CAH's control).

Other measures recommended by the National Advisory Committee, however, have proven less valuable for CAHs, especially given the significant work involved in chart abstraction. Median time to transfer to another facility for acute coronary intervention is impacted by factors beyond the CAH's control, including the availability of ambulance transport and the ability of the other facility to accept the requested transfer. Other measures - including median time from ED arrival to ED departure for discharged ED patients, door to diagnostic evaluation by qualified medical professional, and left without being seen – often do not provide useful information for purposes of performance improvement, given significant variation due to patients' presenting conditions.

AHHA also supports the inclusion of Hospital Commitment to Health Equity measure in the REH Quality Reporting Program. Organizational commitment to cultural change and leadership accountability are critical first steps toward more equitable care. AHHA, however, urges CMS to delay reporting requirements relating to screening for social drivers of health to afford REHs sufficient time to develop streamlined processes to complete and document screenings and report on the measure.

II. Fee-for-Service Reimbursement for REH Services

The authorizing statute defines REH services as "(i) Emergency department services and observation care [and] (ii) At the election of the rural emergency hospital, with respect to services furnished on an outpatient basis, other medical and health services as specified by the Secretary through rulemaking." CMS, however, proposes a more restrictive definition, limiting REH services to those services for which PPS hospitals are reimbursed under OPPS.

However, there are several services within the statutory definition of REH services for which PPS hospitals are reimbursed on other fee schedules, including laboratory services, outpatient therapy services, mammography, and services furnished by opioid use treatment providers. Rather than defining these services as non-REH services to be reimbursed at their respective fee schedule rates, CMS' regulations should remain consistent with the statutory language, including these services within the definition of REH services. Consistent with congressional intent, CMS should provide a 5% add-on to the respective fee schedule payments for these services.

For example, Section 1833(t)(1)(B)(iv) of the Social Security Act excludes from the outpatient prospective payment systems for hospital outpatient services those therapy services reimbursed

under a fee schedule established under Section 1834(k). Under that section, CMS is directed to pay for outpatient therapy services under the fee schedule established under Section 1848, i.e., the Medicare Physician Fee Schedule. Section 1848 affords CMS broad authority in maintaining the Medicare Physician Fee Schedule, and nothing in that statute would prohibit CMS from revising the relevant regulations in 42 C.R.F. Part 414 to provide a 5% add-on for therapy services furnished in an REH.

More robust payment policies will not only encourage more CAHs and rural hospitals to convert, rather than close, but to offer more necessary services after conversion. REHs should receive the extra 5% payment when they determine that their communities need additional services, like outpatient therapy and opioid use treatment, that are not reimbursed under OPPS.

AHHA also requests that Medicare Geographic Classification Review Board (MGCRB) reclassification be allowed for the REH wage index and for the rural floor. REHs should be allowed to apply for reclassification by the MGCRB to reclassify to a higher wage area and receive a higher payment rate.

Finally, AHHA fully supports CMS' proposal regarding payment for services furnished in an off-campus outpatient department of an REH. AHHA agrees the statutory language reflects Congressional intent that REH payments should not vary based on the location of the department in which the service is provided.

III. Monthly Facility Payment

AHHA has carefully reviewed the document CMS released with the Proposed Rule detailing each step in the formula to calculate the monthly facility payment.[1] However, CMS has not published its computation, i.e., the dollar amount assigned to each step in the calculation. The only definite dollar amounts CMS has made available are the total amount of Medicare spending for CAHs in CY 2019 ("Actual Spending"), $12.08 billion, and the total projected amount of Medicare spending for CAHs if paid prospectively in CY 2019 ("Projected Spending"). In the case of the latter, two different amounts are listed in the Proposed Rule: $7.68 billion (87 Fed. Reg. 44786) and $7.03 billion (*Id*. at 44780).

AHHA urges CMS to publish its computation of Actual Spending and Projected Spending to afford stakeholders the opportunity to review and validate the calculation of the monthly facility amount. As discussed below, many questions remain whether CMS considered all relevant factors due to this lack of transparency, especially given the two different amounts listed for Projected Spending. Given the importance of the monthly facility payment to those considering REH conversion, there should be no lingering questions regarding its validity.

Method II billing. Regarding the formula used to calculate Actual Spending, it appears CMS did not include payments for professional services made to those CAHs that elected Method II billing. These CAHs received 115% of the applicable Medicare Physician Fee Schedule rate (multiplied by 110% for services furnished in a health professional shortage area) for services furnished by physicians and non-physician practitioners who re-assigned their billing rights to the CAH. By

[1] CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Calculation of Rural Emergency Hospital (REH) Monthly Additional Facility Payment for 2023*, https://www.cms.gov/files/document/supplemental-documentation-reh-additional-facility-payment-calculation.pdf

failing to include these payments, CMS under-counted Actual Spending, thus reducing the amount of the monthly facility payment.

Ambulance Payments. Also, CMS did not account for the enhanced reimbursement received by those CAHs that operate the only ambulance services within 30 miles of their facilities. CMS should include in Actual Spending the difference between the cost-based reimbursement these CAHs received and the ambulance fee schedule rates these CAHs would have otherwise received. Using this approach, it would not be necessary for CMS to include ambulance payments in Projected Spending.

Regarding the formula used to calculate Projected Spending, it appears CMS failed to properly apply several payment rules, resulting in an over-estimation of PPS payments. These apparent errors result in a proposed monthly facility payment that is less than the amount authorized by statute.

72-hour rule. First, it appears CMS failed to adjust payments to account for the fact CAHs are not subject to the 72-hour rule. Unlike PPS hospitals, CAHs receive full payment for any outpatient diagnostic or other medical services performed within 72 hours prior to a hospital admission. To calculate estimated PPS payments, therefore, CMS would need to exclude any service for which a CAH received payment furnished within the 72-hour window, as a PPS hospital would not have received any payment for those services.

Hospital IQR. Second, in the explanation of the DRG payment calculation, it appears CMS assumed all CAHs would have met all Hospital Inpatient Quality Reporting Program requirements and thus would not have been subject to the reduction in the applicable annual payment rate update. Given CAHs were not subject to similar quality reporting requirements in 2019, it would be appropriate to assume all CAHs would have been subject to this payment reduction.

Promoting Interoperability. Third, it appears CMS did not consider the reduction in the applicable annual payment rate update associated with the Promoting Interoperability program. In this case, CMS should reduce the projected DRG payments for inpatient admissions at those CAHs that were subject to the negative adjustment under this project (i.e., received 100% instead of 101% of costs).

Transfer fraction. Fourth, to calculate DRG payments, CMS compared the "covered days of stay to the Geometric *Mean Length of Stay* of the DRG code, per the post-acute care transfer adjustment policy." Presumably, CMS reduced the amount of DRG payment if the length of stay was less than the geometric mean and the patient was transferred to another facility, to hospice care, or to home with home health services. Due to the 96-hour limit inpatient stays, CAHs frequently transfer patients to their swing beds. Because the post-acute care transfer adjustment policy does not apply to swing bed transfers, CMS should confirm it did not reduce the DRG payment if the beneficiary was transferred to a swing bed. Also, CMS should confirm the transfer fraction was applied only for those DRGs to which the post-acute transfer adjustment policy applies. Neither of these matters is specifically addressed in the Proposed Rule or the document published by CMS with the Proposed Rule.

DSH/UCP add-on payments. Fifth, the method CMS proposes to use to project the amount of DSH/UCP add-on payments CAHs would have received if paid prospectively raises concerns. Despite the fact CAH cost reports include the data elements used to calculate these payments, CMS does not propose to use cost report data due to undefined "data availability and validity concerns." Instead, CMS proposes to project these payments by assigning to each CAH the low-income

percentage and uncompensated care cost percentage of the nearest rural PPS hospital based on "the premise that DSH/UCP are determined by the demographics the hospitals serve." Hospitals, however, are free to establish their own financial assistance policies and charge structures which directly impact uncompensated care. This brings into question the use of hospital proximity as a representative proxy. Absent a reliable method to make projections, CMS should exclude DSH/UCP add-on payments from Projected Spending, as it proposes to do with hospital value-based purchasing program payments.

If CMS goes forward with using proximity as a proxy, AHHA believes only the smallest rural PPS hospitals (1 to 50 available beds) with actual geographic location assignment in a rural area (as opposed to those hospitals classified as rural for payment purposes) should be identified for this purpose, as they are most comparable to CAHs. Also, the PPS hospital should be in the same state as the CAH, given the impact of state policies on rates of uncompensated care.

IME add-on payments. Sixth, CMS' proposed use of proximity as a proxy to project IME add-on payments also raises concern. Unlike DHS/UCP, IME add-on payments are not determined by the demographics the hospitals serve. Instead, IME add-on payments reimburse teaching hospitals for their higher patient costs; hospitals without residency training programs do not receive these payments.

Each CAH's cost report (specifically, Worksheet S3, line 27, column 9) indicates whether the CAH maintained a residency training program. No add-on payments should be included for any CAH that did not have such a program in 2019. If CMS uses proximity as a proxy to calculate IME payments for a CAH that had a residency training program, the same hospital identified using the method detailed above should be used. If that hospital did not receive IME add-on payments in 2019, no add-on payment should be included for that CAH.

Amount of Projected Spending. Regarding the final calculation of the monthly facility payment (i.e., (Actual Spending minus Projected Spending) divided by the number of CAHs in 2019), AHHA asks CMS to address the inconsistency in the reported amount of Projected Spending. As noted above, this amount is reported as $7.68 billion (87 Fed. Reg. 44786) and as $7.03 billion (*Id*. at 44780). CMS uses the former number in calculating the monthly facility payment. If the latter number is used, however, the annual payment rate is increased by $472,298. For a provider considering REH conversion, this higher rate may be the deciding factor in moving forward. And again, this highlights the need for CMS to make available the detailed computation of the monthly facility payment.

Number of CAHs in 2019. Also, AHHA urges CMS to make an adjustment for those CAHs that closed in 2019. For example, Oswego Community Hospital in Oswego, Kansas, closed on February 14, 2019. Horton Community Hospital in Horton, Kansas, closed on March 12, 2019. Rather than counting each of these hospitals as 1.0 for purposes of the final calculation, CMS should count these hospitals as 0.12 and 0.2, respectively. CMS should make the same adjustment for the other four CAHs that closed in 2019. Although the amount of the monthly facility payment would not change significantly, this adjustment acknowledges the impact hospital closures have had on rural communities.

IV. Other Payment-Related Issues

A. SNF Payments

AHHA urges CMS to establish a transition period for those rural hospitals and CAHs with swing bed programs that must convert those programs to SNF distinct part units as part of REH conversion. SNFs were afforded more than a year to prepare for the transition to the Patient Driven Payment Model (PDPM), including development and implementation of new processes and completion of staff training relating to assessments and collection and submission of data. Similarly, CMS should afford an REH at least 18 months to transition to PDPM, continuing reimbursement at the prior swing bed rates for the duration of the transition period.

AHHA also asks CMS to study the impact of eliminating swing bed reimbursement for rural hospitals and CAHs that convert to REHs on the availability of post-acute services in rural communities. If these facilities discontinue post-acute services due to inadequate SNF payments, CMS should be prepared to advocate for supplemental payments to protect rural beneficiaries.

B. Ambulance Payments

Rural hospital leaders considering REH conversion are deeply concerned that the communities they serve will lose access to essential inpatient services. Today, residents must leave their community to receive tertiary or quaternary care. Transportation issues plague these residents, as Medicare coverage for ambulance services is limited. With an REH, residents would have to travel outside their community to receive any level of acute care (absent the opportunity to receive acute hospital care at home). Unless transportation issues associated with patient transfers are addressed, rural residents will face serious inequities in access to acute care services.
CMS proposes to amend 42 CFR 410.40(d) regarding origin and destination requirements to include REHs. In addition to these proposed changes, CMS should add two new subsections to the regulation:

(1) Add a new subsection addressing coverage for facility-to-facility transfers for emergency services: "From a hospital, CAH, or REH to a hospital or CAH for emergency services not available at the hospital, CAH, or REH to which the patient came."

(2) Add a new subsection addressing coverage for hospital-to-SNF transfers: "For a beneficiary who qualifies for SNF or swing bed services following an inpatient stay, from a hospital or CAH to a hospital, CAH, or SNF in the beneficiary's home community for SNF or swing bed services."

These clarifications regarding coverage for ambulance services to align with the REH Program are necessary to ensure appropriate transportation is available to and from communities served by REHs. In many cases, overly strict interpretations of the Medicare coverage rules have resulted in beneficiaries being charged thousands of dollars to access acute care services that previously had been available in their local community. Again, as a matter of health equity, CMS must eliminate this barrier to rural beneficiaries receiving appropriate care.

C. Rural Health Clinic Status

AHHA asks CMS to state explicitly in the REH payment regulations that a provider-based rural health clinic (RHC) that was reimbursed at non-capped rates prior to the rural hospital or CAH's

conversion to an REH will continue to be reimbursed at those rates rather than the national statutory payment limit. This is consistent with the statutory language, specifically 42 U.S.C. 1395x(kkk)(6)(B), which states an REH "is considered a hospital with less than 50 beds for purposes of the exception to the payment limit for rural health clinics under section 1833(f)." Again, this higher reimbursement is necessary to maintain access to services in communities with higher per-visit costs. The potential loss of such revenue may make it impossible for some hospitals or CAHs to pursue REH conversion.

D. Bad Debt Reimbursement

CMS should clarify whether an REH will be eligible for bad debt reimbursement under 42 C.F.R. 413.89. AHHA asks CMS to apply the current bad debt policy of a 35% reduction to REHs, especially because CAHs that convert to REHs should benefit from consistency in anticipated payments. CMS should also make bad debt payments to REHs on a biweekly basis, as they are for PPS hospitals.

E. Participation in the 340B Program

The statute authorizing the 340B Drug Pricing Program, 42 U.S.C. 256b, identifies the types of entities eligible for the program, including certain CAHs and PPS hospitals. In authorizing the REH Program, Congress did not amend this provision to specifically reference REHs, but Congress did not specifically state a rural hospital or CAH that undergoes REH conversion must give up 340B participation. AHHA encourages CMS to amend 42 C.F.R. 10.3 to clarify that "covered entity" includes anu REH that qualified as a covered entity and participated in the program prior to its conversion.

Rural hospital leaders have raised significant concerns over whether to convert without 340B eligibility. Having the option to continue participation in 340B would likely increase the number of rural hospitals and CAHs considering converting to an REH. If CMS should conclude it lacks the authority to permit REHs to participate, AHHA encourages the agency to work alongside Congress to ensure that a statutory change is made to include REHs as covered entities.

F. Method II Billing

Under 42 U.S.C. 1395m(g)(2)(B), a CAH may elect Method II billing, receiving 115% of the Medicare Physician Fee Schedule amount for professional services furnished in its facility. Again, Congress did not amend this statutory provision to make specific reference to REHs, but Congress did not specifically state a CAH that undergoes REH conversion must give up Method II billing. And again, AHHA urges CMS to revise its implementing regulation, 42 C.F.R. 413.70(b)(3), to clarify that a CAH that converts to an REH may maintain its election of Method II billing.

G. Other Payers

Medicare Advantage. The statute authorizing the REH Program and the proposed regulations are silent on Medicare Advantage payments for REHs. At present, MA plans pay cost-based rates to CAHs. If the plans pay REHs under OPPS with no upward adjustment or at a negotiated rate that is less than cost, the conversion will cause revenue loss, which may impact the REH Program's long-term viability. CMS should require MA plans to pay REHs with the same payment methodology as under traditional Medicare. CMS also should address the impact of the REH Program on network adequacy requirements for MA plans.

State Medicaid Programs. Presumably, each state Medicaid program will determine how it will reimburse CAHs. AHHA requests that CMS issue guidance to state Medicaid directors regarding the

REH Program, including guidance regarding the impact of the REH Program on network adequacy requirements for Medicaid managed care organizations. To the extent a state plan amendment would be required to establish REH reimbursement for a state Medicaid program, AHHA urges CMS to create a streamlined process for the submission, review, and approval of such amendments to avoid unnecessary administrative burden and delay.

Marketplace Plans. Finally, to eliminate any future issues, AHHA encourages CMS to publish guidance clarifying that REH services are included in the essential health benefits all marketplace plans are required to cover.

V. Enrollment

AHHA fully supports CMS' proposal to streamline the REH conversion process. To facilitate this process, CMS should issue detailed guidance to and provide in-depth training to its Medicare Administrative Contractors (MACs) regarding the conversion process, including enrollment and claims processing and resolution of outstanding matters (e.g., filing and settlement of cost reports for pre-conversion periods). CMS should identify a specific group of individuals available to assist hospitals and CAHs with any issues arising with the MACs relating to REH conversion.

Additionally, the authorizing statute requires a CAH or hospital applying for conversion to submit a detailed transition plan that lists the services the REH will retain, modify, add, and discontinue, as well as a list of intended outpatient services. CMS should provide detail regarding the form and process for plan submission and approval.

Finally, CMS should make every effort to avoid cash flow issues during the conversion process. Several CAHs experienced significant financial challenges during the conversion process due to delayed payments from Medicare and other payers. In addition to working directly with the MACs, CMS should afford newly converted REHs the opportunity to request and receive advances on monthly facility payments.

AHHA thanks CMS for the opportunity to submit these comments and its continued work to support access to affordable, high quality healthcare services in rural communities.

Please contact me if you have questions at 907-586-4068 or by email jmonk@alaskahha.org

Sincerely,

Jeannie Monk, MPH
Senior Vice President

CC: U.S. Senator Lisa Murkowski
U.S. Senator Dan Sullivan