Sept. 6, 2022  **D R A F T**

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare & Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, S.W., Room 445-G

Washington, DC 20201

***RE: CMS-1772-P, Medicare Proposed Rule to Update the Hospital Outpatient Prospective Payment System for Calendar Year (CY) 2023***

Dear Administrator Brooks-LaSure:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed payment policies for Rural Emergency Hospitals (REHs), a new provider type established by the Consolidated Appropriations Act (CAA) of 2021 to address the growing concern over closures of rural hospitals and promote health equity for individuals living in rural communities. The MHA applauds the CMS for the continued commitment to the needs of more than 60 million Americans living in rural areas, including approximately 1.8 million rural Michigan residents. REH provisions will allow rural hospitals with less than 50 beds and critical access hospitals (CAHs) to convert from their current PPS or CAH status effective Jan. 1, 2023. Please note that this letter focuses on the proposed REH policies and that the MHA submitted separate comment letters focused on the proposed 340-B payment changes and other proposals.

**Payment Policies**

The CMS proposes to pay REHs for all outpatient department services otherwise paid under the Medicare OPPS at 105% of the OPPS rate, including services provided in an off-campus outpatient department of a REH. We appreciate that the CMS proposes to determine beneficiary co-payment based on the standard OPPS rate so that patients do not have a higher out-of-pocket amount. The CMS would identify REH claims in the claims processing system with a REH-specific flag, with the CMS currently defining “REH services” as those services reimbursed under the OPPS. REHs will not be permitted to provide inpatient services and are required to provide emergency department services and observation care and may provide other outpatient medical and health services.

In addition to the 5% add-on, the CMS proposes to provide a fixed monthly payment of $268,294, or approximately $3.2 million annually, to each REH to help cover fixed costs with this amount updated annually based on the hospital market basket update. Both the 5% payment bump plus the fixed monthly payment are vital for helping ensure that these facilities remain financially viable and can continue to provide essential services in their communities.

We support the agency’s proposal to use Medicare claims data to determine the facility payment and ask the CMS to continue to carefully consider the adequacy of the facility payment amount given the extraordinary inflationary increases particularly in labor and supply costs. The MHA also urges the CMS to publish a more detailed methodology of its proposed additional facility payment calculations used to arrive at the $268,294 monthly facility payment since this was not included in the proposed rule. It is also unclear whether the CMS used interim rate data or settled cost report data to establish the rate.

**Non-OPPS Services**

The CMS proposes to pay for non-REH services such as clinical diagnostic laboratory services, outpatient therapy services, and screening and diagnostic mammography at 100% of the applicable fee schedule rate. It is vital that REHs continue to provide these services. **The MHA urges the CMS to provide the additional 5% for non-OPPS services provided at REHs**. We also urge the CMS to apply the additional 5% to opioid treatment providers (OTP) to increase patient access to these services.

**Rural Health Clinics**

The MHA also seeks clarification from the CMS regarding payment for provider-based rural health clinics (RHCs). It is critical that the CMS allow REHs to maintain operation of existing provider-based RHCs grandfathered by April 1, 2021, that meet qualifications for the special payment rules that establish non-capped RHC rates instead of the national statutory payment limit. **We urge the CMS to explicitly state this in the REH payment regulations.**

**7.1% Rural SCH Payment Adjustment**

The MHA also urges the CMS to continue the 7.1% OPPS payment add-on that currently applies for rural sole community hospitals (SCHs) and provide the additional 5% on top of that. This will be a key factor in rural SCH evaluation and consideration of converting to REH designation.

**340B Drug Discount Program**

The MHA urges the CMS to allow REHs to be eligible to participate in the 340B drug discount program. We recognize that the CMS does not have the regulatory authority to allow REHs to participate in 340B. However, we urge the CMS to work alongside the Administration and Congress to ensure that a statutory change is made to include REHs as eligible participants in this important program. Otherwise, losing the benefit of 340B would likely outweigh any benefit gained by converting to a REH.

**Behavioral health services**

The MHA urges the CMS to provide an additional payment in addition to the proposed 5% for behavioral health services provided in the emergency department at a REH given the significant challenges often faced when hospitals try to place patients in an inpatient psychiatric facility. We also urge the CMS to provide new funding in efforts to assist REHs in opening behavioral health crisis stabilization units. The need for these units has been further exacerbated by the COVID-19 pandemic.

**REH Quality Reporting Program (REHQR)**

The CMS seeks to adopt a concise set of important, impactful, reliable, accurate, and clinically relevant measures for REHs that would inform consumer decision-making and promote quality improvement efforts. We appreciate the considerations the agency describes that will inform this work and acknowledge the challenges the CMS will face in determining measures that meaningfully assess quality of care in facilities offering such limited services. For example, the MHA urges the CMS to use only measures that have been endorsed by the National Quality Forum (NQF) in its quality reporting programs (QRPs). The NQF endorsement process identifies measures that meet baseline standards of validity, reliability, and usefulness; the iterative review process incorporates feedback from a variety of stakeholders, including NQF’s Rural Workgroup which reviews measures under consideration for use in other CMS programs for applicability in rural settings. Absent NQF endorsement and ongoing review, measures are less likely to achieve the CMS objectives; however, using only NQF-endorsed measures limits the universe of available measures for consideration in the REHQR.

Similarly, we understand that the CMS is working to transform quality measurement and reporting into a fully digital enterprise as part of efforts to improve accuracy and reduce burden associated with chart-abstraction. However, many rural facilities, including those eligible to convert to an REH, lack the technical and logistical resources needed to report digital quality measures.

The CMS requests comment on a selection of measures recommended by the National Advisory Committee on Rural Health and Human Services. It is challenging to provide meaningful input to the CMS on the appropriateness of these OQR and other measures, past and present, since the precise mix of services that REHs will provide is still under development. In the June 2022 proposed rule seeking comment on potential Conditions of Participation for REHs, the CMS requested feedback on several aspects of potential REH services including low-risk childbirth-related labor and delivery, outpatient surgical services, and use of certain advance practice providers for on-call coverage. Since it has not yet been established specifically what care will be provided in an REH, it is difficult to comment on the appropriate metrics to assess care.

Further, we anticipate the mix of services provided will vary greatly by facility. For example, some REHs may see a high volume of acute coronary interventions, so the OQR measures evaluating time to application of fibrinolytic therapy or transfer would be relevant. For other facilities that see high volumes of other types of procedures, such as orthopedic or respiratory, these measures would hold little value. Even if the CMS develops a broad set of measures, the variation in volumes—not just by procedure, but by year—would likely result in REHs across the country reporting disparate combinations of these measures over time.

This leads to the broader question of the goals of the REHQR. Other QRPs have dual purposes: one, to evaluate performance for establishing benchmarks, hold providers accountable and help providers improve quality; and two, to inform individuals in their decisions on where to seek care. Patients served by an REH are likely not going to be using quality information to choose a location for care; REHs were established as a new provider type to allow rural hospitals that are not able to sustain full hospital operations to instead provide a limited set of essential health care services to the communities they serve. Like any health care provider, REHs will be responsible for delivering the best possible care but given their unique nature it is difficult to apply the goals of a QRP for general acute care or other traditional provider type to an REH.

The MHA is unable at this time to support or oppose any of the individual measures listed in the proposed rule. We will better be able to provide meaningful input once more specific expectations for REHs and the services they are to provide are established.

**Medicaid DSH eligibility (1% and OB services)**

Some rural hospitals that are evaluating REH conversion receive Medicaid disproportionate share hospital (DSH) payments, which will be a key factor in determining feasibility of conversion. Existing federal regulations require hospitals to have a minimum of 1% Medicaid utilization rate, which is an inpatient day measure, and provide obstetrical services. **The MHA urges the CMS to modify the federal DSH requirements to grandfather existing hospitals that convert to an REH to continue receiving Medicaid DSH if they received a Medicaid DSH payment in one of the last the last 3 years.**

**Timing**

Based on the CAA, REH enrollment is scheduled to begin Jan. 1, 2023, which is roughly 60 days after the anticipated release of the OPPS final rule. **The MHA urges the CMS to provide further guidance on key issues in a timely manner to enable hospitals to make informed decisions.**

**Summary**

The MHA appreciates this opportunity to provide comments to the CMS on the proposed REH provisions and believe that our proposed changes will have a positive impact on REHs and the rural communities they serve. If you have questions regarding this comment letter, please contact me at vkunz@mha.org.

Sincerely,

Vickie Kunz

Senior Director, Health Finance