June 9, 2023

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: 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; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician-Owned Hospital Requirements; and Provider (CMS-1785-P)

Submitted online at: https://www.regulations.gov/docket/CMS-2023-0057/document

Dear Administrator Brooks-LaSure,

Louisiana Rural Health Association (LRHA) is pleased to offer comments on the FY 2024 IPPS Proposed Rule.

LRHA is a membership association that is made up of Louisiana rural health care providers. This includes rural health clinics (RHCs); federally qualified health centers (FQHCs); and rural hospitals across the state. LRHA works to provide a unified voice that promotes and enhances the quality of rural health in Louisiana.

In this letter, we offer comments to several of the proposed provisions and Requests For Information (RFIs), which include the payment provision, wage index policy provision, hospital value-based purchasing program provision, geriatric hospital designation provision, and the RFI related to the safety net hospital question.

We strongly recommend that CMS review the comments submitted by the National Rural Health Assocation (NRHA) to get further information about how this rule, if finalized, would impact rural health across the country. The NRHA is a national leader in rural health policy and is LRHA's national partner.

Proposed Provisions

Extending Low Wage Index Policy

We commend CMS for extending the low wage index policy. We agree that a full four year period of wages in applicable rural hospitals will provide a balanced approach to measuring the accuracy of wages, given the disruption in the markets and shortage of health professionals.

Hospital Value-Based Purchasing Program

We support the addition a health equity scoring adjustment to the Total Performance Score (TPS) in this program. However, we recommend that the health equity adjustment include a measure of uncompensated care and sole Medicaid enrollment. Louisiana has the second highest poverty rate in the nation, with 8.7% of the population living in deep poverty.[1] Our rural providers serve a patient population with higher rates of poverty (21.6%) than their urban counterparts (17.1%).[2] Due to these disparities, our rural hospitals bear a greater financial burden of uncompensated care and Medicaid undercompensated care and their patients face significant barriers to improving their health outcomes. Therefore, we believe that accounting and adjusting for the health disparities indicated by uninsured and Medicaid enrollment rates in the value-based care program, will assist in mitigating financial penalization of our rural hospitals for the economic environment of the communities that they serve.

Geriatric Hospital Designation

We appreciate that CMS is working with stakeholders to improve access to providers that can care for the geriatric population. However, we are concerned that rural hospitals will not benefit from, and may be negatively impacted by, creation of a geriatric hospital designation. Rural hospitals are often the sole hospital within their communities and some areas of Louisiana have only one hospital serving several rural parishes. Most of our residents, especially in rural areas, want to receive care as close to home as possible and many do not have the means to travel for care when needed. Therefore, patients are less likely to "shop around" and select a hospital based on a designation. Additionally, our rural hospitals have limited resources to meet current administrative and reporting demands. A program that requires additional reporting, even simple attestation, requires resources that many of our small rural hospitals cannot provide without additional financial compensation. However, larger, more urban centers with more resources, will likely be able to easily obtain and market this new designation. We are concerned that this distinction will imply to patients that these urban hospitals are "safe" for geriatric patients and, by default, their local community hospital is "unsafe" when, in reality, the distinction is solely based on ability to report data, not ability to provide high-quality care to this patient population. We believe that for a designation to provide any true value to both the hospital and the patient population, additional compensation must be provided for reporting of these data.

Requests for Information

Safety Net Hospitals

Payment Indices

We are encouraged that CMS recognizes the additional costs of safety net hospitals through DSH, uncompensated care payments, and other payment designations like SCH, CAH, REH. In developing a new index that could be used to determine payment for safety net hospitals, we strongly suggest that CMS consider combining elements from both the Safety Net Index (SNI) and Area Deprivation Index (ADI). The SNI measures patient characteristics at a given hospital and the ADI measures population health in general. In consideration of the SNI, lower rates of private insurance and higher rates of uncompensated and undercompensated care, place a disproportionate financial burden on rural hospitals. When these patients are discharged from the facility, they face significant health disparities and lack of resources to follow their care plan and maintain their health. With the increased focus on overall patient outcomes, hospitals often feel penalized for the health disparities that exist in the communities that they serve that are outside of their control.

[1] Louisiana Budget Project
[2] USDA Economic Research Service, Sate Fact Sheets: Louisiana

As indicated above, our rural providers serve a disproportionate share of patients living in poverty. Social services and support organizations that patients may need to access in order to address social determinents of health (SDOHs) are often in urban-based centers. With little or no access to public transporation, and limited resources to own and maintain a vehicle, many rural residents have limited or no access to services that are outside of their immediate community. Many rural hospitals provide uncompensated services to help meet the needs of their patients. For example, many hospitals provide transportation services free of charge for patients to attend medical appointments. However, increases in financial burdens to hospitals make providing these services more difficult. Financial assistance to rural providers to cover the cost of patient transportation would increase provider ability to provide this service and, thereby, increase patient access to care.

IT Infrastructure

One barrier to adoption of IT infrastructure is lack of financial incentives. Financial incentives have been proven to achieve the outcome of increasing technology adoption by rural providers. For example, the meaningful use program, which provided incentive payments for electronic health record (EHR) adoption, has resulted in 99% of small rural hospitals adopting EHR systems. With the transition to the Promoting Interoperability Program, there is a need to not only maintain, but also continue to upgrade and improve IT infrastructure in order to continue effective use of the systems and implement new initiatives and features, such as new APIs. However, as the program no longer offers financial incentives to offset expenses, our rural providers do not have the financial resources to keep up with the increasing cost of maintaining and upgrading IT infrastructure. Rural providers face a number of barriers to implementation and utilization of health information technology, including lack of access to affordable vendors/consultants, difficulty in recruiting qualified HIT staff, and lack of internet/broadband infrastructure in rural communities.[3] Rural hospitals that are already facing significant financial challenges would require additional financial incentives/reimbursement in order to truly meet their HIT infrastructure needs.

LRHA thanks CMS for the opportunity to comment on this proposed rule. If you would like additional information, please contact Denaé Hebert at dhebert@lrha.org or 337.366.5915.

Sincerely,

Denaé M. Hebert
Executive Director
Louisiana Rural Health Association

[3] Skillman SM, Andrilla CH, Patterson DG, Fenton SH, Ostergard SJ. Health information technology workforce needs of rural primary care practices. J Rural Health. 2015 Winter;31(1):58-66. doi: 10.1111/jrh.12081. Epub 2014 Jul 25. PMID: 25066067.