



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: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating**

Dear Administrator Brooks-LaSure,

Louisiana Rural Health Association (LRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the calendar year (CY) 2023 Outpatient Prospective Payment System proposed rule. We appreciate CMS' continued commitment to the needs of the more than 60 million Americans that reside in rural areas.

LRHA is a membership association that is made up of Louisiana rural health care providers. This includes rural health centers (RHCs); federally qualified health centers (FQHCs); and rural hospitals across the state. Through discussion and exploration, the LRHA works to create a clear understanding of rural health care in Louisiana, its needs and effective ways to meet these needs.

LRHA thanks CMS for the opportunity to comment on this proposed rule.

## **II. Propose Update Affecting OPPI Payments**

### *B. Proposed Conversion Factor Update*

LRHA has significant concerns about the low payment update (2.7%), particularly given the inflationary environment and continued labor and supply cost pressures that hospitals and health systems face. Although our rural communities are wonderful places to live and work, these areas have historically struggled with workforce recruitment and retention and provider shortages. The current and ongoing labor pressures that are occurring across the country only compound and exacerbate the underlying disparities in rural areas and put a significant financial and logistical strain on our rural healthcare facilities. Therefore, we ask CMS to adjust the proposed payment update to better reflect the current economic reality that rural hospitals are facing.



CMS uses the same market basket percentage update for the OPPS rate as in the Inpatient Prospective Payment System (IPPS) proposed rule,<sup>1</sup> which CMS projected to be 3.1%. The final IPPS rule was published on August 10, 2022, and included an increase to the proposed market basket update by using second quarter 2022 forecast data. CMS finalized a market basket update of 4.1%, the largest update in 25 years. We ask that CMS adopt this market basket update in the final OPPS rule to increase payments in alignment with the increased IPPS payments. Because rural hospitals provide a more significant portion of outpatient services compared to inpatient, receiving the higher market basket update will be especially important to rural hospital viability.

### *C. Proposed Wage Index Changes*

LRHA is pleased to see that CMS 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 labor demands, can contribute to significant fluctuations in the wage index, and a cap on any decrease will mitigate those factors. However, we urge CMS to apply this cap in a non-budget neutral manner for rural hospitals. There is substantial variation in the hospital wage index adjustment of rural and urban hospitals. 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.

## **V. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals**

### *B. Proposed OPPS Payment for Drugs, Biologicals, and Radiopharmaceuticals without Pass-Through Payment Status*

#### **6. OPPS Payment Methodology for 340B Purchased Drugs**

We thank CMS for reinstating the average sales price (ASP) plus 6% payment rate for 340B drugs in light of the Supreme Court decision in *American Hospital Association v. Becerra*, 596 U.S. \_\_\_\_ (2022).

In order to make hospitals whole, we encourage CMS to remedy the cuts by repaying hospitals the full amounts that were lost to the ASP -22.5% policy from CY 2018 to 2022. Additionally, CMS should not implement the change through a budget neutral manner that takes funds from hospitals exempted from the payment cuts.

## **X. Nonrecurring Policy Changes**

### *A. Mental Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes*

LRHA thanks CMS for taking steps to help overcome the challenges that rural Americans face in obtaining critical mental health services. Covering mental health services furnished remotely by hospital staff to patients in their homes will increase access and options for Medicare beneficiaries requiring mental health



care. We also commend CMS for permitting Critical Access Hospitals (CAHs) to bill for these services even though CAHs are not paid under OPSS.

LRHA recommends that the clinical staff furnishing remote mental health services do not need to be “in” a hospital outpatient department while providing services to beneficiaries in their homes. We hold that 42 C.F.R. § 410.27(a) should be amended to include an exception for mental health services furnished to remote patients.

We also support CMS’ proposal to continue the use of audio-only technology for mental health services post-COVID-19 Public Health Emergency for beneficiaries who cannot use audio/video technology due to broadband limitations. Rural areas are more likely to have limited access to broadband and have benefitted greatly from audio-only visits. The flexibility and reimbursement to provide telehealth services to our rural patients is of significant importance to our rural providers and we thank CMS for support on these matters.

#### *E. Supervision by Nonphysician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients*

We support the ability of nonphysician practitioners to practice at the top of their license and clinical training. We thank CMS for proposing that nonphysician practitioners may provide general, direct, and personal supervision of outpatient diagnostic services, per state scope of practice laws. Workforce flexibilities are crucial for rural providers that face enduring challenges in recruiting and retaining an adequate workforce. Nonphysician practitioners are critical to maintaining and increasing access to health care in rural areas as they are the primary care providers for many of our rural patients and will continue to be with broader supervision privileges.

### **XVIII. Rural Emergency Hospitals (REH): Payment Policies, Conditions of Participation, Provider Enrollment, Use of the Medicare Outpatient Observation Notice, and Physician Self-Referral Updates**

#### *A. Rural Emergency Hospital Payment Policies*

##### 4. Payment for Services Performed by REHs

LRHA is pleased with CMS’ proposal to include all outpatient department services otherwise paid under OPSS as REH services payable under the REH payment policy. We also applaud CMS for the monthly payments proposed for CY 2023. Robust payments for REHs will ensure that facilities are financially feasible and can continue to provide essential services to the surrounding rural communities.

However, we urge CMS to add the additional 5% to non-OPSS services provided at REHs. For example, outpatient therapy services should be paid under the respective fee schedule plus the additional 5%. In its proposed Conditions of Participation for REHs, CMS notes that REHs may be interested in becoming opioid treatment providers (OTP).<sup>ii</sup> To encourage REHs to do so, CMS should also consider applying the additional 5% to OTP services paid under the Physician Fee Schedule.



LRHA also requests clarification from CMS on payment for provider-based rural health clinics (RHCs). Consistent with legislative intent,<sup>iii</sup> CMS must provide guidelines for payment to REH provider-based RHCs. CMS must allow REHs to maintain operation of existing provider-based RHCs grandfathered by April 1, 2021, that meet the qualifications in section 1833(f)(3)(B) of the Social Security Act for the special payment rules that establish non-capped rates instead of the national statutory payment limit.<sup>iv</sup> This must be explicitly stated in the REH payment regulations.

Many of Louisiana's rural communities rely on the care of RHCs, including provider-based RHCs, which provide care to many of our most vulnerable residents. The loss of any RHC in Louisiana would be devastating to the community it serves and decrease the already limited access to primary care in rural areas across the state. Explicit allowance for REH's to maintain provider-based RHCs and the provider-based special payment rule help to ensure continued access to necessary care through RHCs.

Additionally, we would like to see REHs become eligible to participate in the 340B program to ensure access to medications. We recognize that CMS does not have the regulatory authority to allow REHs to participate in 340B, however, we ask that the CMS and the Administration work alongside Congress to ensure that a statutory change is made to include REHs as eligible participants.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. If you would like additional information, please contact Denaé Hebert at [dhebert@lrha.org](mailto:dhebert@lrha.org) or 337.366.5915.

Sincerely,

A handwritten signature in black ink, appearing to read "Denaé", written over a light blue horizontal line.

Denaé M. Hebert, MBA/HCA, CHC, CRHCP  
Executive Director  
Louisiana Rural Health Association

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<sup>i</sup> 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. 87 Fed. Reg. 28403 (May 10, 2022) (to be codified at 42 C.F.R. pts. 412, 413, 482, 485, and 495).

<sup>ii</sup> Medicare and Medicaid Programs; Conditions of Participation (CoPs) for Rural Emergency Hospitals (REH) and Critical Access Hospital CoP Updates. 87 Fed. Reg. 40360 (July 6, 2022) (to be codified at pts. 42 C.F.R. 485 and 489).

<sup>iii</sup> 42 U.S.C. § 1395x(kkk)(6)(B) (2018) ("A rural emergency hospital may be 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)").

<sup>iv</sup> CENTERS FOR MEDICARE AND MEDICAID SERVICES, *Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2022*, (Nov. 19, 2021) <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/R11130CP.pdf>.