

Comments on CMS FY 2023 Proposed Rules for IPPS Hospitals/Other Facilities and Requests for Information CMS-1771-P

Overview

The Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (DHHS) released proposed rules [CMS-1771-P] entitled, *“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.”* The proposed rule includes multiple *Requests for Information* (RFIs) on specific topics. These comments are the response of the National Organization of State Offices of Rural Health (NOSORH) to this publication.

The National Organization of State Offices of Rural Health (NOSORH) was established in 1995 to assist State Offices of Rural Health (SORH)s in their efforts to improve access to, and the quality of, health care for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state’s rural communities to build effective health care delivery systems.

NOSORH is encouraged by the wide-ranging questions raised in the proposed rules and RFIs. NOSORH’s response is selective, addressing key issues of particular concern to SORHs and the rural health care system. In addition to general comments, NOSORH presents specific recommendations for how DHHS/CMS policy and guidance can better address the needs of the rural health care system.

Comments and Recommendations

Issue - Proposed Condition of Participation (CoP) Requirements for Hospitals and Critical Access Hospitals (CAHs) to Report Data Elements to Address Any Future Pandemics and Epidemics as Determined by the Secretary

Overview

In the published rule, CMS proposes to require supplemental reporting by hospitals and CAHs related to COVID-19 and respiratory diseases beyond the period of the current Public Health Emergency (PHE). CMS also proposes that, as determined by the Secretary, hospitals and CAHs be required, during future PHEs, to submit additional data as may be useful in combatting future pandemics and epidemics. NOSORH recognizes the value of these proposals, as is discussed below.

Discussion

During the current COVID-19 Public Health Emergency (PHE) the supplemental data reporting required from hospitals and other health facilities provided near real-time insight into the progression of the pandemic. Combined with the general population testing data, hospital generated data yielded detailed insight about the relative seriousness of the pandemic in different communities. Using public datasets, NOSORH created a mapping tool for SORHs, which provided an updated picture of the progression of the pandemic in rural communities. SORHs were able to coordinate with rural health care providers and others to plan responses to emerging outbreaks.

After the termination of the PHE, there will be a need to continue the expanded reporting in order to assure that infections rates and hospitalizations do not rebound. Similarly, in the future, there may be a need to impose supplemental reporting for other PHEs. While such reporting imposes a moderate burden on health facilities – particularly smaller facilities in rural communities – NOSORH believes that the value of these data far outweighs the cost.

Comments/Recommendations

NOSORH supports the proposed extension of PHE-required reporting for COVID-19 and pneumonia by both hospitals and CAHs beyond the end of the PHE.

NOSORH also supports the imposition of supplemental reporting requirements related to any future PHEs. NOSORH suggests that, in the case of future PHEs, the Secretary assure that any supplemental reporting is not overly burdensome on smaller, rural facilities.

Issue - Proposed Performance-Based Payment Program Adjustments

Overview

Several CMS performance-based payment programs assess hospital payment penalties/incentives based on yearly hospital performance. The COVID-19 pandemic has had a significant impact on typical hospital performance, and could potentially lead to program penalties for many hospitals. In the published rule, CMS proposes to make adjustments designed to offset the impact of non-typical hospital performance related to the COVID-19 pandemic.

Discussion

The COVID-19 pandemic has created substantial challenges for hospitals. Many of the performance baselines from pre-pandemic periods are not indicative of hospital operations after the onset of the COVID pandemic. This can create difficulties with evaluation under key CMS performance-based payment programs, including:

- Hospital Value-Based Purchasing (VBP) Program

- Hospital-Acquired Condition (HAC) Reduction Program
- Hospital Readmissions Reduction Program (HRRP)

In its published rules regarding these programs, CMS proposes to modify the measures being considered in performance evaluation, change the base performance evaluation periods, suspend some of the scoring, and minimize the potential program penalties. These adjustments attempt to offset the special circumstances created by the COVID pandemic.

Comments/Recommendations

NOSORH supports the proposed adjustments to these key CMS performance-based payment programs. These adjustments should help modify the performance-based payment programs that assess the impact of the COVID pandemic on hospital performance.

NOSORH notes that the impact of the pandemic will likely trail off over the next few years. This will make any future program adjustments more challenging.

<h2>Issue - Proposed Establishment of a Publicly-Reported Hospital Designation to Capture the Quality and Safety of Maternity Care</h2>
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Overview

NOSORH strongly supports the establishment, by CMS, of a hospital maternal health quality designation based on appropriate measures. NOSORH believes, however, that a focus exclusively on maternal health is too limiting. As is suggested by the initial designation title '***Birthing Friendly Hospital***', a more appropriate focus would include both maternal and neonatal care. NOSORH notes that the proposed basis for designation includes adoption of specific maternal care improvement processes. NOSORH believes that this is also a limited perspective, and that the basis for designation should include ***adoption of quality improvement processes, monitoring of quality indicators, progress in quality improvement and improved care outcomes*** – both for maternal and neonatal health care.

A detailed discussion of NOSORH's recommended approach to designation follows.

Discussion

▪ Topic - Proposed Designation Title

NOSORH believes that the phrase *Birthing Friendly Hospital* is not a good description for what is being designated. The phrase suggests a number of aspects about maternity and delivery care that may not be present in a designated facility. For example, an expectant mother might anticipate that a *birthing-friendly hospital* would have dedicated birthing suites and might employ specialized support staff during the birthing process, such as birthing doulas.

Comment/Recommendation:

NOSORH recommends that a better phrase for what is being designated might be Birthing-Conscious Hospital. This phrase would encompass a hospital that monitors key maternal and neonatal/perinatal health process and outcome indicators and has in place care improvement processes linked to these measures.

▪ **Topic - Focus of Birthing Hospital Quality Designation**

NOSORH believes that the proposed basis for designation of birthing-friendly hospitals is very narrow. The adoption of maternal outcome quality improvement processes is important, but does not address the full range of issues associated with good birthing outcomes. The question of neonatal/perinatal health is not addressed at all in the proposed designation. NOSORH believes that these issues should be given equal weight to maternal health outcomes in any designation.

NOSORH is comfortable with the proposed use of eQMs for the Hospital IQR Program—the Cesarean Birth and Severe Obstetric Complications - as measures to be used in evaluating maternal health outcomes. NOSORH recommends, however, that other maternal and perinatal measures be added to the core measures.

NOSORH notes that there are multiple process improvement schema that address the broader range of maternal and neonatal/perinatal health outcomes. For example, AHRQ has prepared a Perinatal Safety Toolkit with evidenced-based steps for improving both maternal and neonatal/perinatal health.

- <https://www.ahrq.gov/hai/tools/perinatal-care/index.html>

The processes include steps to reduce preventable neonatal injury and death. Similarly, the Institute for Healthcare Improvement has multiple resources available for improving maternal and neonatal/perinatal outcomes and preventing obstetrical adverse events.

- <http://www.ihl.org/Topics/Maternal-Infant-Health/Pages/default.aspx>

Comment/Recommendation:

NOSORH recommends that CMS not base any birthing hospital quality designation solely on adoption of quality improvement processes, but also on monitoring of quality indicators, progress in quality improvement and improved care outcomes – both for maternal and neonatal health care.

▪ **Topic - Non-Hospital Care Impact on Maternal and Neonatal Health Outcomes**

It should be noted that services provided at a delivery facility do not exclusively determine maternal and neonatal outcomes. Other non-delivery facility factors, including level of prenatal care, maternal nutrition and maternal health can be important. Both maternal and infant health outcomes are significantly affected by these non-hospital factors, and the future selection of outcome measures will

likely need some manner of risk adjustment related to these factors to make the hospital outcome measurements truly comparable.

Comment/Recommendation:

NOSORH recommends that CMS establish, as part of a birthing hospital quality designation methodology, an appropriate risk adjustment mechanism for rural hospitals based upon the adequacy of perinatal care, maternal nutrition and similar, non-hospital factors.

NOSORH also recommends that CMS consider, as part of a birthing hospital quality designation methodology, required hospital systems of coordination with non-hospital prenatal care services for patients. This will assure that information about patients arriving for labor and delivery services will be available, including information about any high-risk or special conditions that could affect the delivery and post-partum care.

- **Topic – Rural Patient Access to Maternal and Infant Health Services**

Rural counties have a significantly lower availability of maternal and infant health services than do urban counties. While this is true for many services, the lack of availability of obstetrics/delivery services in rural communities poses the most serious challenge for national maternal and infant health policy.

A study published in Health Affairs in 2017 found that more than half of all rural counties in the United States, with 2.4 million women of reproductive age, had no hospital obstetric services. These communities may have no hospital or may have a hospital without obstetric services. This means that residents of half of the nation's rural counties must travel to find obstetric services – often for prohibitive distances.

The Health Affairs study noted that 9 percent of rural counties lost obstetric services in the period of 2004-2014. This decrease in rural service availability is part of a long-term trend. The trend was confirmed in a separate study by Chartis, which showed that between 2011 and 2018, 134 rural hospitals – 12% of all rural hospitals with OB services – ceased to provide OB services. Added to this number was an additional 18 facilities that ceased operations altogether. The combined impact meant that 152 rural communities lost access to OB services in this time period.

This Chartis analysis also showed that only 46% of America's rural hospitals (1,011) currently provide labor & delivery services. A related Commonwealth Fund analysis indicates that the lack of these services is also associated with poorer access to prenatal care services for rural mothers. The Chartis analysis describes this shortage of basic care as a maternity desert in a majority of the nation's rural communities.

The Chartis study indicated that the closure of obstetric services at rural hospitals during this period was due largely to declining volumes and poor financial performance of the services. Financial challenges, such as low Medicaid

reimbursement and the high cost of malpractice insurance, are significant barriers to keeping financially stressed obstetrics units open in rural hospitals. The closures impacted nearly 450,000 women of reproductive age, who are now without maternity care in their home counties.

A NOSORH survey of individual SORHs confirms the obstetric and prenatal care availability problem highlighted in these studies. SORHs uniformly identified the lack of local obstetric services as a major obstacle to good maternal and infant health care. Most SORHs indicated that pregnant women in rural counties must travel at least 30 to 60 minutes to secure obstetric care – either from OB/GYNs or OB-trained family practitioners. Several states indicated that multiple communities were faced with 1-2 hour travel times for these services.

It should be noted that pregnancy service payment arrangements can compound the access problem for residents of rural counties without local hospital delivery services. Payments for pregnancy services, including obstetrics, are often bundled. A single payment is made to a health provider covering both prenatal care and normal delivery. This creates an additional barrier to access – rural residents must travel to distant communities for both their prenatal care and delivery services. While it is possible for a health provider to split their fees with prenatal care providers in a patient's home community, it is highly unlikely that this will occur.

SORHs responding to the NOSORH survey confirmed the existence of this problem. SORHs linked the bundled payment problem to a lack of local access to prenatal care for pregnant mothers in rural communities without local hospital OB services. Multiple SORHs indicated that local family practices in these communities could be enlisted to provide accessible prenatal care, but that collaborative arrangements with out of area delivery services would need special payment arrangements.

SORHs also pinpointed two additional access issues of importance. Several SORHs noted that patient cost-sharing for prenatal care and delivery services – administered as co-pays or up-front costs – were associated with delays in starting and reduced overall use of prenatal care. This results in poorer birth outcomes. In addition, several SORHs noted that the limited Medicaid coverage of post-partum care for mothers – typically limited to 60 days – is a problem for maternal health. SORHs recommended that a full year of coverage is preferable.

Workforce shortages complicate the question of maternal and infant health service supply. For example, in locations with some prenatal care and delivery capacity, provider shortages will lead to a supply of services less than demand for these services. As a result, some pregnant mothers may need to wait to get the care they need or may receive fewer than the optimal number of provider visits.

At a national level, there are significant maternal and infant health service provider shortages. The Association of American Medical Colleges has estimated that, in 2020, the nation had 8,000 fewer obstetrician/gynecologists than were

needed. Similar shortages exist for other provider types, both clinical and non-clinical. The distribution of the available workforce is also a major problem – one which further exacerbates the supply shortage. Rural areas have the greatest shortages of crucial maternal and infant service providers. A Commonwealth Fund report indicates that fewer than half of all rural counties have even one practicing obstetrician or gynecologist.

Clinical maternal and infant health care services are provided by obstetricians, family practice physicians, certified nurse midwives, advanced practice nurses, general surgeons and pediatricians. Anesthesiologists and certified nurse anesthetists may also be needed for deliveries requiring surgery. Most of these providers are not dedicated full-time to maternal and infant health care, and are called upon to serve a broad range of patients. Many rural counties are designated health professional shortage areas, facing substantial shortages of providers. Maternal and infant health service providers working in health professional shortage areas will find a greater the demand on their practice time for other types of services. This can further reduce the effective number of providers supplying maternal and infant health care.

Delivery services can be provided by obstetricians, trained family/general practitioners, certified nurse midwives and licensed midwives. For non-vaginal deliveries, general surgeons may be required. Studies have shown that rural counties have fewer of these providers per 10,000 population than do urban counties. This is a significant disparity in rural America. High risk pregnancies may require additional clinical services from endocrinologists, pediatric specialists and other medical specialists. Rural counties have far fewer of these specialists available, making it more difficult to manage high-risk maternal conditions.

Care coordination and adjunct services, including prevention education services, are provided by a range of providers, including community health workers, health educators, social workers, doulas and nurses. There is also a shortage of these providers in many rural communities. This increases the difficulty in accessing the full range of maternal and infant health services in rural America.

SORHs responding the NOSORH survey have emphasized the problems created by health service provider shortages in their rural counties. SORHs identified the difficulty in attracting highly trained providers and the even greater difficulty in retaining them. Maternal and infant health practice in rural areas can be challenging. In general, call schedules are more rigorous than in urban areas. Work and education opportunities for a provider's family are more limited than what is available in urban areas. Clinical support for high-risk pregnancies may be inadequate or non-existent. SORHs prioritized this issue as one needing special attention.

There are multiple negative impacts for rural women resulting from the lack of access to maternal and infant health services. These are documented in multiple reports and studies linked at the end of these comments. Some studies identify higher rates of premature birth for rural mothers who must travel longer distances

to obstetric services. Other studies report higher rates of elective deliveries – including induced deliveries and caesarian sections – for rural mothers needing to travel longer distances for obstetric services. Additional studies have highlighted higher maternal morbidity and complications for rural mothers needing to travel longer distances to access obstetric services.

SORHs responding to the NOSORH survey confirm these findings. In addition, individual states report, for their rural counties:

- Lower use of prenatal care and preventive services,
- Later entry into prenatal care, and
- Higher rates of neonatal intensive care unit use.

The Alaska SORH reported a highly sobering statistic. Sixteen (16) maternal deaths were reported in 2017-2018 – of these, 12 were women who resided in rural communities.

This is consistent with other studies which show that maternal mortality risk is not evenly shared – and that Native American, Alaskan Native and Black women are three to four times more likely to die from pregnancy-related issues than Hispanic and white non-Hispanic women.

Comments/Recommendations:

NOSORH believes that the relative lack of access of rural patients to needed maternal and infant health services is a risk factor that should be considered in the evaluation of service quality at rural hospitals and regional hospitals serving rural populations. As the CMS designation of quality birthing hospitals is developed to look at maternal and neonatal outcomes, this increased risk must be considered. ***NOSORH recommends that CMS establish, as part of a birthing hospital quality designation methodology, an appropriate risk adjustment mechanism for rural hospitals and regional hospitals serving rural populations.***

NOSORH notes that a hospital's maternal/neonatal outcomes can be influenced by a hospital's discharge planning and coordination efforts. Both mothers and infants should leave a hospital with a clear plan for follow-on services and a formal handoff to ongoing care. ***NOSORH recommends that CMS consider, as part of a birthing hospital quality designation methodology, hospital provisions for follow-on services including home visiting for both mother and infant, with scheduled screening to identify potential subsequent problems such as maternal post-partum depression.***

NOSORH also believes that a full range of maternal and neonatal services may not be available at a given rural hospital, but that all services should be accessible through any rural hospital. For example, while a rural hospital may not have a neonatal ICU, the hospital should have established mechanisms for transport of high-risk neonates to such a unit. ***NOSORH recommends that CMS consider, as a part of a birthing hospital quality designation methodology, appropriate hospital coordination and referral mechanisms for all needed***

specialty maternal and neonatal care. These mechanisms should be part of coordinated regional maternal and neonatal service systems.

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

Overview

NOSORH believes that the current systems for emergency preparedness planning, response and recovery are not fully adequate for dealing with future climate-related emergencies. Within the health care sector, much focus has been on individual provider responses, with limited participation in broader, multi-provider regional systems. CMS licensing and certification standards provide for fairly good regional coordination in all-hazards planning for hospitals, but have much lower requirements for other providers, including CAHs, FQHCs and RHCs:

- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/EP-Rule-Table-Provider-Type.pdf>

It is anticipated that future climate-related emergencies, including wildfire, flooding, heat and drought emergencies – will be more intense, wider spread and longer in duration. Health care emergency preparedness systems must adapt to these anticipated changes.

Discussion

The recent New Mexico wildfire experience provides a good example of how an extended climate-related emergency can impact health care providers. The Hermit's Peak/Calf Canyon fire is currently the largest active wildfire in the nation as well as the most extensive wildfire in NM history. It has burned about 300,000 acres (468 square miles) and is on track to continue to grow.

The fire's burn and evacuation zones include multiple small communities and has, thus far, led to the evacuation of an FQHC, an EMS service, a public health office and the state psychiatric hospital. The health facilities of these evacuated services are still intact, but it is unclear if they have sustained smoke or other damage. The patients of these services have all been evacuated – some to adjoining communities and others to more dispersed locations, such as Albuquerque, which are more than 150 miles away. More than 10,000 local residents have been evacuated. Some evacuees are in shelters, some are quartered in motels/hotels, and others are staying with friends and family. The start date for the fire was April 6, 2022 – the climate-related event is in its sixth week and is anticipated to continue for several more weeks before the mandatory evacuations are lifted.

Each health care provider faces unique challenges in this climate-related emergency, only a few of which were anticipated in their provider-specific all-hazards response planning. The case of an FQHC is a case in point. It illustrates the complexity of the challenges. FQHCs have only limited preparedness requirements under CMS licensing and certification standards, yet these organizations and their patients have complicated needs during a CR-related emergency.

The patients of FQHCs may face significant challenges when they are evacuated and the FQHC facility has been shuttered. They may need health care services at new providers and there is no guarantee of care availability or continuity. There is no assurance of continuity of care as their medical records may not be available at the new sites. Those patients with chronic illness and medication needs may not have adequate supplies of their medications, and may not be able to secure a copy of their prescription for use in their evacuation location. There is no automatic transfer of registration and payor information to health care providers at the evacuation site, and re-registration and payment re-qualification will need to occur. For FQHC patients who receive subsidized care on a sliding fee discount schedule, they may not find affordable care available at an alternative provider using the same discount schedule. For patients who did not bring records with them as they evacuated, they may not be able to provide alternative providers with the documentation needed to assure application of the discount schedule.

FQHC organizations face their own challenges. FQHCs must secure their facilities, equipment and records for the period of evacuation. FQHCs, where possible, may need to arrange for accessibility of patient information, as permitted by HIPAA, to other health care providers at evacuation locations. FQHC grant requirements will need to be adjusted for the period of evacuation. FQHCs will need to make decisions about redeployment or furlough for their staff – both clinical and administrative. Reassignment to alternative providers to help in managing the surge in demand from evacuees is not a straightforward process. Supervision arrangements must be established with the new providers. Clinicians may need to be credentialed for payors at the new locations. Revenue sharing agreements – permitting reassigned staff to generate revenue for their home FQHC – may need to be negotiated. Malpractice/FTCA questions may also complicate reassignment. Lastly, human resources and compensation/benefits decisions will need to be made for any furloughed staff.

These challenges are made more difficult by extended evacuations and relocations. While temporary arrangements can be established for the short-term, longer-term arrangements can be problematic. For example, evacuees in the NM wildfire event were told to prepare for 3-7 days of evacuation. The actual event has lasted far beyond this into weeks and months. This puts incredible strain on both patients and health care providers. It is particularly difficult for lower-income patient families.

Longer-term emergencies also put strain on limited emergency funding and other resources. For example, in the short run, Disaster Medical Assistance Team (DMAT) deployments are helpful. As climate-related emergencies run for longer periods, the resources providing support for these teams may be exhausted. It should be noted that as climate change increases, climate related emergencies will likely become more intense, cover greater areas and last longer. Preparedness planning and emergency response must change to accommodate these anticipated impacts.

Comments/Recommendations

The complexity of the ongoing New Mexico wildfire event highlights the difficulty of establishing an effective, coordinated health system response, particularly in rural areas. NOSORH understands that no one agency or one level of government can

manage a system response to assuring surge capacity and care continuity for evacuees. NOSORH believes, however, that DHHS and CMS can implement changes and initiatives that can greatly assist in future major climate-related emergencies.

NOSORH's recommendations for DHHS and CMS are detailed below:

- **Expand facility-level emergency preparedness requirements for all providers:**

NOSORH recommends that the current CMS facility level emergency preparedness requirements be expanded. The expansion should include specific requirements for all certified facilities - including FQHCs, RHCs and CAHs – related to emergency planning, communications planning, training/testing and emergency policies/procedures.

- **Provide support for development of regional health care system preparedness plans for climate-related emergencies:**

NOSORH recommends that DHHS provide support for the development of regional health care system preparedness plans for climate-related emergencies. The plans should include both *short-term*, *long-term*, and *post-event* components, including *recovery* considerations and support from SORH and other state partners. The plans should be comprehensive, and include:

- Evacuation/Transfer pre-arrangements for different types of providers. These arrangements should assure
 - Systems for patient care continuity
 - Data Mobility, including medical record data, registration data and billing data
- Pre-arrangements for deployment of DMAT and other health care emergency resources.
- Surge capacity estimation, permitting appropriate reallocation of patients, staff and resources under various scenarios.
- Pre-arrangements for staff reassignment during an emergency.
- Preliminary post-emergency recovery planning, including pre-arrangements for patient transfer and repatriation.