South Dakota
Association of Healthcare Organizations

3708 W. Brooks Place • Sioux Falls, SD 57106 • (605) 361-2281

September 5, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

RE: CMS-1809-P; Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs, Including the Hospital Inpatient Quality Reporting Program; Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals; Prior Authorization; Requests for Information; Medicaid and CHIP Continuous Eligibility; Medicaid Clinic Services Four Walls Exceptions; Individuals Currently or Formerly in Custody of Penal Authorities; Revision to Medicare Special Enrollment Period for Formerly Incarcerated Individuals; and All-Inclusive Rate Add-On Payment for High-Cost Drugs Provided by Indian Health Service and Tribal Facilities.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure.

The South Dakota Association of Healthcare Organizations (SDAHO) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for the Medicare Hospital Outpatient Prospective Payment System for calendar year (CY) 2025. We appreciate CMS' continued commitment to the needs of rural Americans, and we look forward to our continued collaboration to improve health care access in our rural community.

SDAHO serves as a voice for South Dakota's hospitals and healthcare organizations encompassing the full continuum of care. SDAHO members include hospitals, healthcare systems, nursing facilities, home health agencies, assisted living centers, and hospice organizations. SDAHO's mission includes advancing healthy communities across the healthcare continuum.

OPPS Payment Updates

SDAHO thanks CMS for its 2.6% payment update relative to CY 2024. **We are pleased to see that rural hospitals across the board will have a slightly higher payment update at 2.8%.** However, **we continue to be concerned about the discrepancy between Medicare payment rates and actual inflation.** For July 2024, the Consumer Price Index for hospital services was 6.1% meaning that Medicare reimbursement will continue to fall behind the actual cost of providing care to

beneficiaries.[1] Compounding CMS' underpayment, rural hospitals and health systems also face labor and supply cost pressures and workforce shortages. The projections that CMS uses for updating payment rates have recently been lower than actual inflation because historical data is used. Using historical inflation data leads to inadequate payment updates.

After all of the productivity, budget neutrality, and other adjustments, the estimated impact for South Dakota PPS facilities is an increase of only 2.22%, which is well below the inflation rates. The lowest projected impact for a facility in South Dakota is an increase of only 1.21%.

Changes to the Review Timeframes for the Hospital Outpatient Department (OPD) Prior Authorization Process.

SDAHO applauds CMS for shortening the prior authorization timeline for Medicare fee-for-service (FFS) outpatient requests to 7 calendar days. We appreciate that CMS is aligning the timeline for standard outpatient department requests with that of other payers. This proposal will create equity for all patients waiting to access care and may help reduce provider burden by streamlining processes across all payers.

Health and Safety Standards for Obstetrical Services in Hospitals and Critical Access Hospitals.

SDAHO commends CMS for its continued focus on ending rural maternal health disparities. **Between 2011 and 2021, 267 rural hospitals ceased providing obstetrical (OB) care, representing 25% of rural America's OB units.**[2] These closures are threatening access to care and contributing to the rural maternal health crisis. Unfortunately, as rural hospitals face difficult financial situations, closing service lines is an intermediary step before closing the hospital. Given the low volume of births in rural areas, coupled with financial challenges and workforce shortages generally experienced by rural hospitals, OB units are one of the first service lines to be ended.

To help address maternal health outcomes nationwide, CMS proposes new OB services conditions of participation (COPs) and amendments to emergency services and Quality Assessment and Performance Improvement (QAPI) COPs. We appreciate CMS' goal of improving maternal health outcomes so long as rural access to care is not inadvertently threatened.

[1] Press Release, Bureau of Labor Statistics, Department of Labor, Consumer Price Index – July 2024 (Aug. 14, 2024), https://www.bls.gov/news.release/pdf/cpi.pdf.
[2] Topchik, et al., *Rural America's OB Deserts Widen in Fallout From Pandemic*, Chartis (2024), 1, https://www.chartis.com/sites/default/files/documents/rural_americas_ob_deserts_widen_in_fallout_from_pandemic_12-19-23.pdf.

Provisions of the Proposed Regulations.

SDAHO urges CMS to exempt rural hospitals and CAHs from the proposed COPs. Again, we agree with and supports CMS' mission to address and improve maternal health outcomes. **However, we are extremely concerned with the current trend of OB unit closures and the impact that complying with requirements in the new COPs will have on the remaining OB units in rural hospitals. We maintain that imposing one-size-fits-all COPs on rural hospitals and CAHs will lead to more OB unit closures.** Research suggests that lack of access to hospital-based OB care worsens outcomes and lowers the likelihood of adequate prenatal care.[3] **Imposing additional COPs on vulnerable rural hospitals and CAHs will ultimately cut against CMS' goal of improving maternal health outcomes.** Rural hospitals disproportionately rely upon Medicare and Medicaid reimbursement as they make up the majority of their patient population. **The magnitude of the effect of not complying will have a chilling effect on rural hospitals such that they will preemptively cease providing OB care to preserve their participation in Medicare and Medicaid.**

Losing OB services at a rural facility in South Dakota could cause patients to be required to drive two or more hours away to another facility providing these services. OB services are already becoming more scarce across the state, so anything that would put the other services at risk could be detrimental to our rural communities.

Further, CMS is soliciting comments on whether the proposed COPs should apply to rural emergency hospital (REHs). **SDAHO strongly urges CMS against applying OB and related COPs to REHs.** REHs have their own distinct set of COPs that in many places, but not all, align with CAH COPs. The REH designation was created as a lifeline for certain rural hospitals that may otherwise close. As such, REHs have their own distinct payment methodology and COPs and should not be required to comply with COPs that other rural hospitals do. While we do not have any facilities that have applied for REH status in our state, this may be something they look at in the future.

1. Organization, Staffing, and Delivery of Services (§ 482.59 and § 485.649).

CMS proposes COPs related to the organization, staffing, and delivery of services in an OB unit. Many of the proposals may already be happening in rural hospitals, such as maintaining a roster of practitioners' privileges or training relevant OB staff on maternal care. **However, it is not appropriate to mandate these practices with the threat of noncompliance resulting in loss of Medicare and Medicaid participation.** We appreciate the flexibility given in certain areas such as not prescribing who or how hospitals train staff on OB care and allowing flexibility around which evidence-based guidelines to use for developing protocols around OB emergencies. **Nonetheless, we**

[3] Stephanie M. Radke, et al., *Closure of Labor & Delivery units in rural counties is associated with reduced adequacy of prenatal care, even when prenatal care remains available*, 39 J. RURAL HEALTH 746, 750 (2023) https://onlinelibrary.wiley.com/doi/epdf/10.1111/jrh.12758.

do not believe additional mandates are the answer to improving maternal health in rural areas and urge CMS to relieve rural hospitals and CAHs of these requirements.

We are particularly concerned around requirements for equipment at proposed § 482.59(b) § 485.649(b). CMS proposes that hospitals and CAHs have a call-in-system, cardiac monitor, and fetal doppler or monitor available to labor and delivery room suites. We ask that CMS clarify its definition of "available." Many rural hospitals and CAHs likely have this equipment available to the unit but not in every labor and delivery room. CMS should allow flexibility around equipment requirements and allow hospitals to have this equipment available in relation to patient needs. For example, if a CAH typically has one patient in its OB unit at any given time, one set of equipment for the unit should be sufficient to meet this requirement.

One way CMS can help improve rural maternal health outcomes is to assist rural hospitals with OB readiness. SDAHO asks that CMS provide resources, such as technical assistance, to help rural hospitals achieve this goal. A broad emergency services readiness COP, described below in Section 3, is redundant and will not further readiness for OB emergencies. For example, S. 4079/H.R. 8383, the Rural Obstetric Readiness Act[4] would help prepare rural hospitals and providers to handle the obstetric emergencies that come into their emergency rooms. This would be achieved through supporting facilities with the purchase of necessary equipment and developing a workforce that is able to respond, creating a pilot program to support statewide or reginal networks of obstetric care teams to provide tele-consultation, and creating an obstetric emergency training program for rural facilities that do not have a labor and delivery unit. While this program would be housed in the Health Resources and Services Administration, it can serve as a model for the kind of technical assistance that CMS could help provide.

2. Quality Assessment and Performance Improvement (QAPI) Program (§ 482.21; § 485.641).

CMS proposes that hospitals and CAHs that offer OB services be required to use their QAPI programs to assess and improve outcomes and disparities among OB patients. Again**, SDAHO urges CMS to exclude rural hospitals and CAHs from this proposal.**

If CMS moves forward with finalizing this proposal, we ask that CMS provides flexibility around the requirement to incorporate Maternal Mortality Review Committee (MMRC) data and recommendations into hospitals' QAPI programs. Almost every state has a statewide MMRC meaning that their state data or recommendations may be more urban-centric and not relevant to or representative of rural hospitals. CMS should allow hospitals to instead use data and recommendations from any body that is working on OB quality in their area.

[4] Rural Obstetrics Readiness Act, S. 4079, 118th Cong. (2024) https://www.congress.gov/bill/118th-congress/senate-bill/4079.

South Dakota
Association of Healthcare Organizations

3708 W. Brooks Place • Sioux Falls, SD 57106 • (605) 361-2281

3. Emergency Services Readiness (§ 482.55; § 485.618).

SDAHO urges CMS against finalizing this addition to emergency services COPs. The new provisions under § 482.55 and § 485.618 would apply to all emergency services. **These provisions are redundant as hospitals and CAHs must meet existing emergency services COPs and comply with EMTALA.** Adding an additional set of emergency services COPs on rural hospitals and CAHs will be a financial, administrative, and staff burden that many of these struggling providers cannot shoulder.

The proposed provisions are duplicative for CAHs in particular and must not be finalized. The new proposals would require adequate provisions and protocols to meet the emergency needs of patients. CAHs are already meeting a similar, if not almost identical, standard at § 485.618(b)-(c). Additionally, CMS proposes to add that CAHs must have a physician immediately available by phone on a 24/7 basis to receive emergency calls, provide information on treatment, and refer patients to the CAH or another location. Yet CAHs must currently comply with a similar requirement in § 485.618(d) which requires that a practitioner be on call or immediately available by phone and available onsite within 30 minutes on a 24-hour basis.[5] CMS' proposal would require that a physician, rather than a non-physician practitioner, be available by phone 24/7, which is more difficult to meet in the face of the workforce shortages that CAHs experience. **We assert that CAHs are presently meeting an extremely similar standard regarding emergency services and the existing standard was designed with rural workforce limitations in mind.** Therefore new one-size-fits-all standards are not appropriate and will result in additional untenable burdens for CAHs.

Thank you for the opportunity to comment on this proposed rule. We look forward to continuing to work together towards our mutual goal of improving health care and access for rural Americans. If you have any questions or would like to discuss further, please contact Tim Rave at Tim.Rave@sdaho.org.

Sincerely,

Tim Rave

President/CEO

South Dakota Association of Healthcare Organizations

[5] In frontier areas, the practitioner must be available within 60 minutes.