National Rural Health Association

June 5, 2023

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

RE: CMS-1779-P; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2024

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) fiscal year (FY) 2024 Skilled Nursing Facilities 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, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

III. Proposed SNF PPS Rate Setting Methodology and FY 2024 Update.

CMS proposes to update skilled nursing facility (SNF) payments by 3.7%, or $1.2 billion, compared to FY 2023 payments. This translates to a 3%, on average, increase in payments for rural SNF providers. **NRHA thanks CMS for the increased payments for FY 2024** but encourages the agency to maximize support for rural SNFs as the public health emergency winds down and facilities are recovering from the COVID-19 pandemic. The long-term care sector was hit hard by the pandemic and rural SNFs are still wrestling with workforce challenges, increased costs, and facility closures. Between 2008 and 2018, 472 rural closed in the U.S, with 10% of rural counties being nursing home deserts.[1]

D. Wage Index Adjustment.

NRHA understands that wage index adjustments must be budget neutral by law; however, **we express our disappointment that rural SNFs will uniquely see a downward adjustment in their**

[1] Hari Sharma, et al., *Trends in Nursing Home Closures in Nonmetropolitan and Metropolitan Counties in the United States, 2008-2018*, RUPRI CENTER FOR HEALTH POLICY ANALYSIS, Feb. 2021, at 3, https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf.

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payment rates due to the wage index. Nationwide SNFs are projected to see a 0% adjustment in their payment rate for wage index, but rural SNFs would face a -0.7% decrease. This is particularly challenging given the severe workforce shortages facing rural SNFs for the full range of healthcare providers, especially certified nurse aides and nurses.

VI. Skilled Nursing Facility Quality Reporting Program (SNF QRP).

C. SNF QRP Quality Measure Proposals.

NRHA supports the proposed modification and removal of four measures in the SNF QRP. CMS anticipates that for some of the measures being removed the time and cost associated with reporting would decrease. However, one proposed measure for adoption, the Short Stay Discharge Measure, would have more significant impacts on administrative burden on rural SNFs. Adoption of the Discharge Function the Percent of Patients/Residents Who Are Up to Date on COVID-19 Vaccines measures would have a negligible impact on staff time. **NRHA reminds CMS that rural SNFs face more acute workforce shortages and struggle to take on additional reporting requirements and appreciates that CMS is minimizing new reporting burdens in this rulemaking cycle**.

D. Principles for Selecting and Prioritizing SNF QRP Quality Measures and Concepts Under Consideration for Future Years: Request for Information (RFI).

2. Guiding Principles for Selecting and Prioritizing Measures.

NRHA thanks CMS for noting that reducing burden is one part of its goals for selecting and prioritizing SNF QRP measures. The usefulness of quality measures should be weighed against the administrative burden on rural SNFs. This is crucial for rural facilities that tend to face more serious staffing shortages and thus their workforce is stretched thin. Additional administrative burdens that may not affect most SNFs will be more difficult to comply with for rural and understaffed facilities. Rural facilities are less likely to pay for administrative professionals or coding staff that can dedicate their time to reporting requirements.

E. Health Equity Update.

We appreciate CMS' continued commitment to and focus on health equity, including for rural beneficiaries. **NRHA supports including social determinants of health measures in future quality reporting.** Health equity data in SNF QRP would be a valuable tool for CMS and providers to evaluate performance and inform future policies to close quality gaps for rural beneficiaries.

CMS could incorporate screening measures similar to those adopted in the FY 2023 Inpatient Prospective Payment System (IPPS) final rule in the SNF QRP.[2] One measure is the Hospital Commitment to Health Equity which could be adapted to SNFs. The other measures were related to SDOHs: Screening for Social Drivers of Health Measure[3] and the Screen Positive Rate for Social

[2] Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates. 87 Fed. Reg. 48780, 49191, 49194 (Aug. 10, 2022) (to be codified at 42 C.F.R. pts. 412, 413, 482, 485, and 495).
[3] *Id.* at 49202.

Drivers of Health Measure.[4] NRHA expressed its support for these measures in its comment on the FY 2023 IPPS proposed rule and did not believe that these screenings and associated reporting would create undue burden on providers.[5] Additionally, information on SDOHs and social risk factors are important for rural providers to understand about their patient population. Oftentimes rural populations are at the intersection of several indicators or health disparities – race and ethnicity, income level, plus geographic location. These populations face compounding issues like poverty, language barriers, lack of educational attainment, and low health literacy, all of which add up to poorer health outcomes. This may be more pronounced in older, rural beneficiaries that require skilled, post-acute care.

NRHA applauds any future efforts in the SNF QRP to collect information that may help close disparities in health between rural and urban beneficiaries.

VII. Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program: Proposed Policy Changes.

E. SNF VBP Performance Scoring Methodology.

4. Proposal to Incorporate Health Equity into the SNF VBP Program Scoring Methodology Beginning with the FY 2027 Program Year

NRHA supports CMS' proposal to include a Health Equity Adjustment in the SNF VBP Program insofar as it does not hurt rural SNFs that do not qualify. NRHA believes that the payment adjustment for performing well on this proposed measure is appropriate to account for the increased resource utilization associated with furnishing quality care to dual eligible beneficiaries.

CMS is proposing to use dual eligible beneficiaries to define "underserved population" for the adjustment. Dual eligible beneficiaries make up about 5% of the rural population, or around 2.6 million people.[6] Rural dual eligible beneficiaries are a small enough population to fall through the cracks, thus deepening existing health disparities and exacerbating already worse health outcomes compared to non-dual eligibles. NRHA appreciates that CMS proposes to use dual eligible beneficiaries as a proxy for social risk factors and negative health outcomes in the Health Equity Adjustment and we agree with CMS that dual eligible status is a good indicator for resource increased utilization in SNFs and identifying low-resourced facilities. CMS may consider adding beneficiaries eligible for the Part D low-income subsidy in its definition of "underserved population" as well.

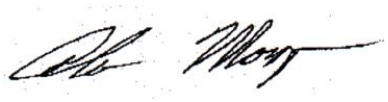
IX. Civil Money Penalties: Waiver of Hearing, Automatic Reduction of Penalty Amount.

[4] *Id.* at 49215.
[5] *See* National Rural Health Association comment on Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates. https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2022/NRHA-FY23-IPPS-Final-Comment.pdf.
[6] Ellen Breslin, Samantha Di Paola, & Susan McGeehan, *The Health Equity & Access for Rural Dually Eligible Individuals (HEARD) Toolkit*, HEALTH MANAGEMENT ASSOCIATES (Jan. 2023), https://www.healthmanagement.com/wp-content/uploads/RuralAccessToolkit_R6.pdf.

NRHA supports CMS' proposal to remove the requirement to submit a written request to waive a hearing and replace it with a constructive waiver process. We support removing an administrative burden considering that most facilities waive their right to a hearing according to CMS' data.

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We very much look forward to continuing our work together to ensure our mutual goal of improving quality and access to care. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,



Alan Morgan
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