RUPRI Health Panel
Keith J. Mueller, PhD, Chair
Alva O. Ferdinand, DrPH, JD
Alana D. Knudson, PhD
Jennifer P. Lundblad, PhD, MBA
A. Clinton MacKinney, MD, MS
Timothy D. McBride, PhD
Nancy E. Schoenberg, PhD
https://rupri.org/

June 9, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4201-P
By electronic submission at http://www.regulations.gov

Dear Administrator Brooks-Lasure:

RE: CMS-1785-P: Medicare Program: Proposed Hospital PPS for Acute Care Hospitals and the Long-Term Care Hospital PPS and Policy Changes and Fiscal Year 2024 Rates

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to this proposed rule, focused on sections that fall within the scope of our expertise.

DHS and Uncompensated Care Payments (p 26986)
The RUPRI Health Panel concurs with the methodologies used to calculate both the Medicare DSH payment and uncompensated care payments. We note that Factor 2, which uses measures of uninsurance, is subject to considerable change following disenrollment from Medicaid and changes in the Health Insurance Marketplace (HIM) as provisions in the Public Health Emergency expire (including the final expiration of provisions affecting the HIM that have been extended). Given the changing dynamics, we encourage CMS to continue monitoring impacts on hospital finance to potentially account for necessary balancing payments through DSH.

Potential Future Inclusion of Two Geriatric Care Measures (p 27103)
The RUPRI Health Panel applauds CMS for working to develop measures of geriatric care that are clinically meaningful, address overall quality of care for our geriatric population, and are feasible for all providers to utilize and report. We note that two members of the Panel (Lundblad and Mueller) were participants in Measure Application Partnerships (Hospitals and Rural Health Advisory Group) that reviewed and commented on these measures during their development. The Panel finds the domains to be appropriate. However, we do not believe there should be duplication between attestation statements used for Hospital Domains and Surgical Domains. Such duplication creates unnecessary burden. CMS posed a series of questions (**p 27109); t**he Panel responds here with a series of statements regarding burdens on rural hospitals:

- We assume the question of burden encompasses the burden of implementing the necessary protocols and other changes allowing affirmative attestation rather than the administrative burden of the act of reporting, although with 14 measures across 8 domains there is an obvious need for administrative time and effort, which is why the Panel calls attention to duplicative measures.
- Small rural hospitals may struggle to stand up the full array of protocols across the 8 domains, although given the typical patient mix of those institutions (a high percentage

of elderly patients), these measures will serve as clear guidance for actions they need to undertake.

- Recognizing the constraints that may preclude 100 percent compliance with the measures (e.g., Pain Management "where possible"; "appropriate reporting and involvement of social services in Domain 6) will be helpful to all hospitals, but especially helpful for low-volume rural hospitals.
- Rural hospitals will face particular challenges in establishing communications with post-acute care facilities upon discharge (Domain 7) in places where there are no facilities in close proximity. Recent closures of nursing homes in rural communities creates special challenges that will require establishing new relationships and more reliance on the hospital's own services combined with services that may be available in the community.
- Many rural hospitals will be challenged to designate a geriatric champion (Domain 8); technical assistance will be needed to help them define the qualifications and functions, and to find creative ways to fill the staffing needs (e.g., perhaps in collaboration with area agencies on aging that may support the activity in multiple low-volume rural hospitals)
- CMS should phase-in any geriatric care hospital designation to allow an awareness campaign to be sure all hospitals are fully engaged in programming to achieve the highest possible score. This will be especially challenging for small rural hospitals.
- The Panel recommends alignment of language across all CMS measures related to social determinants of health. In the 2023 IPPS rule, the language used in the Social Drivers for Health Measure and the Screen Positive Rate for Social Drivers of Health Measures is "health-related social needs" rather than psychosocial risk factors.
- In terms of potentially duplicative of existing measures, the Hospital Inpatient Quality Reporting (IQR) Program includes a Social Determinants of Health (SDOH) Screening measure (to be fully implemented in 2024) which would presumably cover Domain 6, Attestation Statement 9, of the General Hospital Measures. This would be unnecessary reporting burden, particularly in small rural hospitals. Of the five categories hospitals are required to screen for, interpersonal safety is one of them, which could conceivably cover Domain 6, Attestation Statement 10, of the hospital measure, although the IQR measure does not require any reporting (although all health care providers are mandated reporters so if there is a screen positive for abuse, depending on the state, they would be required to report).

Safety Net Hospitals – Request for Information (p 287187)

The RUPRI Health Panel applauds the effort to recognize the critical role played by safety net hospitals in providing access to all Medicare beneficiaries, as being essential points of access to the communities they serve. We understand that a primary focus of any safety net provider policy will be institutions serving disproportionate percentages (compared to all institutions) of uninsured and underinsured populations, resulting in burdens of uncompensated care. Further, we understand, as a matter of Medicare payment policy, an emphasis on low-income Medicare beneficiaries (Medicare Low-income Subsidy Enrollment Ratio) in developing an index to identify safety net hospitals, as well as the Medicare share of total inpatient days. However, we encourage CMS to rethink the Safety Net Index to reflect the role of hospitals as the anchor of the health care delivery system in many rural communities. While there are payment policies recognizing special circumstances of rural hospitals (e.g., sole community hospitals, Medicare-dependent hospitals, critical access hospitals), we recommend that any new designation of

safety net hospitals take into account the reality of the hospital being *the sole* source of supportive health care services in many rural communities.

In response to the questions posed in the Request for Information (**page 27189)** the RUPRI Health Panel offers the following comments:

- *Considerations in identifying safety net hospitals:* These considerations should include financial burden of serving community members lacking insurance coverage that reimburses full cost of providing the service. Equally important, there should be consideration of what health services would be available in the absence of the hospital.
- *Factors not to consider*: We have no comment.
- *Different types of safety-net hospitals*: Safety-net hospitals could be characterized based on financial measures (i.e., the SNI), the characteristics of their service area and population (I.e., the ADI), or the essential nature of the hospital to assuring the pillars of a high performing rural health system: a baseline consideration of equity with pillars of access, affordability, quality, and community.
- *Main challenges facing safety*-net hospitals: In a rural context the main challenges are adapting to changes in health care delivery and finance, specifically how to succeed under terms of value-based arrangements. A second challenge is evolving into a service provider with a different mix of services (e.g., ambulatory care versus inpatient services), but maintaining capacity for a comprehensive range of services given no local alternatives due to insufficient population base.
- *New approaches or modifications of existing approaches requiring statutory authority*: We have no comment.

Respectfully submitted,

Keith J. Mueller, PhD
Chair, RUPRI Health Panel
University of Iowa
College of Public Health
145 N Riverside Drive
Iowa City, IA 52242
Keith-mueller@uiowa.edu
www.rupri.org