MHA Michigan Health & Hospital Association | Leading Healthcare

June 7, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

***RE: CMS-1746-P, Medicare Program: Skilled Nursing Facility Prospective Payment System for Fiscal Year 2022 Rates; Proposed Rule***

Dear Ms. Brooks-LaSure:

The Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services' (CMS) regarding the fiscal year (FY) 2022 proposed rule to update the **Medicare Skilled Nursing Facility (SNF)** prospective payment system (PPS). For the hospital-based SNFs in Michigan, this rule is expected to increase Medicare fee-for-service (FFS) payments by just $113,300, or 0.8%, in FY 2022. The MHA remains concerned about the financial viability of SNFs since the latest data indicates that Michigan hospital-based SNFs have a negative 47 percent margin for services provided to Medicare patients. This is particularly concerning given the COVID-19 pandemic and the additional challenges it has created.

## FORECAST ERROR ADJUSTMENT

The CMS proposes a market basket increase of 2.3% for FY 2022 based on fourth quarter 2020 forecast from IHS Global Insight, Inc. with historical data through the third quarter 2020. The CMS is also rebasing the SNF market basket from 2014 to 2018.

For FY 2020, the most recent year for which actual data are available, the CMS applied a market basket of 2.8% but the actual increase was 2%.Since the difference of 0.8% exceeds the percentage point threshold for making a forecast error correction, the CMS is proposing to apply a 0.8% adjustment to the FY 2022 SNF market basket and invites comments on whether the agency should eliminate the forecast error adjustment to raise the threshold from 0.5 to 1 percentage points for applying the adjustment in future rulemaking.

**The MHA urges the CMS to eliminate the forecast error adjustment which is estimated to reduce payments to Michigan's hospital-based SNFs by $118,600 in FY 2022.** Upon initial implementation of this adjustment in FY 2003, the CMS evaluated several years of data and indicated that a "*major reason the SNF market basket forecast was under-forecasted for previous periods was that wages and benefits for SNF workers increased more rapidly than expected*." The agency went on to say that "*This faster-than-expected increase occurred primarily because the health sector continued to grow rapidly despite the economic downturn, and also because of the impacts of nursing staff shortages and other conditions generally affecting the health care market".* The CMS has not applied the forecast error adjustment in years which demonstrates that it's no longer needed and SNFs are receiving appropriate payments.

**If the CMS opts to not eliminate the adjustment, the MHA urges the agency to withdraw its proposal for this year given that FY 2020 data used to assess the error adjustment reflects data**

**and activity during the COVID-19 pandemic and response.** The CMS has recognized this data challenge for other PPS settings/policies and should make the same consideration here.

**PATIENT DRIVEN PAYMENT MODEL PARITY ADJUSTMENT**

The CMS seeks input on how to recalibrate the patient driven payment model (PDPM) "parity adjustment" that is designed to ensure budget neutrality under the new PDPM as compared to the former Resource Utilization Groups (RUGS-IV) classification system while also ensuring that SNFs can meet the financial demands of the COVID-19 pandemic. The CMS' analysis shows that FY 2020 SNF PPS payments are higher than the expected spending. The most recent data available, FY 2020, indicates that the PDPM model overall will pay SNFs 5% more in FY 2020 than would have been paid under the former RUGS-IV system. As a result, the CMS believes that a recalibration of the PDPM parity adjustment is warranted for budget neutrality purposes.

The COVID pandemic posed significant challenges, including fiscal challenges, for healthcare providers particularly nursing homes. Absent the various waivers instituted by the CMS to support nursing homes during the pandemic, many Medicare beneficiaries would likely have faced severely reduced access to needed critical care. **The MHA urges the CMS to withdraw its proposal for FY 2022 since the FY 2020 data used to assess the parity adjustment reflects data during the pandemic and response. We also recommend that the CMS to make available a public use file at the nursing home level for the industry to assess this adjustment.** Even though the CMS attempts to account for patients with a COVID diagnosis in their analysis, we have concerns that the pandemic likely reduced service volume and spending and may not be accounted for by the CMS in its assessment of the parity adjustment. For example, as referenced by the CMS, the PDPM has resulted in reduced therapy hours and SNF spend. We anticipate a significant decline in these hours and other support services to nursing home residents during the pandemic as nursing homes were locked down in Michigan and throughout the United States. **If the CMS opts to move forward with a parity adjustment, the MHA urges an extended phase-in that reduces PDPM payments by a maximum of 1% annually until the parity adjustment is achieved.**

**SNF QUALITY REPORTING PROGRAM**

SNF Healthcare-Associated Infections Requiring Hospitalizations Measure

The proposed *SNF HAIs Requiring Hospitalizations* measure for FY2023 would estimate the risk-standardized rate of HAIs that are acquired during SNF care which result in hospitalization. The MHA is supportive of efforts to continue to reduce HAIs, recognizing that these events are associated with longer lengths of stay, use of higher-intensity care, and increased mortality.

**However, we oppose the SNF HAIs Requiring Hospitalizations measure and believe this claims-based measure is flawed and fails to provide meaningful information for stakeholders.** In addition, the measure is not currently endorsed by the National Quality Forum (NQF) and panel members have indicated that the two- to three-year time lag for claims-based measures makes it difficult to make meaningful improvements. Facilities have expressed the need for more timely information to make the data more relevant in their conversations with patients, leadership, and internal staff. The time lag on this measure results in inaccurate information about a facility's performance.

**SNF ADOPTION OF COVID-19 VACCINATION AMONG HEALTHCARE PERSONNEL (HCP) MEASURE**

The MHA appreciates that this proposed measure represents an effort by the CMS to advance measurement to address the public health emergency and provide consumers with data to make an informed decision when choosing a SNF. **However, we believe that advancing this measure prior to full approval by the Food and Drug Administration (FDA) is premature. As such, we oppose the adoption of this measure at the present time for reasons highlighted below.**

*Vaccine hesitancy*

The COVID-19 vaccines are currently approved through an emergency use authorization and a significant number of Americans have chosen not to be vaccinated because of concerns regarding serious adverse events, the compressed timeline for development and approval, and general mistrust of the government and public health community. Vaccine hesitancy has created challenges among the general public and among HCP.

*Unintended consequences and legal risk*
If this measure were adopted and publicly reported, SNFs would be held accountable for HCP vaccinations. The MHA is concerned that some SNFs may choose to mandate that HCP receive the vaccine as a strategy to achieve high performance, creating ethical and legal issues. Mandating the vaccine may also result in HCP leaving their positions, putting an additional strain on an already challenged workforce with many vacant positions in not only SNFs but across all healthcare settings. MHA members have also expressed concern about the legal risk to their organization if HCP experience an adverse event related to the vaccine. We also believe publicly reporting HCP vaccination rates may inappropriately pit facilities against one another based on public opinion regarding the vaccine.

*Timeliness*
Given the time-sensitive nature of this measure, the CMS proposed to use a shortened reporting period (October-December 2021) for the FY 2023 program year, followed by quarterly reporting deadlines starting with the FY 2024 program. The MHA questions whether this information will be of value in 2023 and beyond for quality improvement or consumer-decision making given the time associated with data collection, submission, and validation.

We support and encourage that consumers have access to real-time meaningful data to help inform healthcare decision-making but believe that the use of a single, dated measure is not a true reflection of the safety or quality of care delivered at the SNF.

*Duplicative reporting is administratively burdensome*
The MHA recognizes that COVID-19 vaccination reporting is already required by the Michigan Department of Health and Human Services via the Michigan Care Improvement Registry (MCIR) system. We believe that requiring additional HCP vaccination data to be reported into the NHSN is redundant and burdensome particularly as SNFs struggle to meet current COVID-19 data reporting requirements at the state and national level.

**While the MHA opposes the adoption of the COVID-19 HCP vaccination measure in any of the quality reporting programs for FY 2022, we understand the intent of the measure and urge the CMS to consider the following:**

- **Delay the measure adoption until the vaccine has been given full approval by the FDA and the measure specifications are complete and have been endorsed by the NQF.**
- **Utilize HHS TeleTracking COVID-19 vaccination data to track vaccination rates at the facility level.**
- **Direct consumers to use the HHS TeleTracking site as the data is reflective of current HCP vaccination rates.**

**REQUEST FOR INFORMATION: CLOSING THE HEALTH EQUITY GAP**
Upon the 2017 launch of the "Patients over Paperwork" Initiative, the CMS' goal was to reduce unnecessary regulatory burden and enable providers to concentrate on their primary mission of improving patient health outcomes which is supported by the MHA and other stakeholders.

The CMS outlines several areas within this RFI in which additional quality measures and standardized patient assessment data elements (SPADEs) may be implemented in the future. **The MHA has significant concern about adding additional SPADEs since this may ultimately increase burden and negatively impact patient experience.**

As CMS considers additional measurement to address health equity, **the MHA urges the CMS to honor its "Patients Over Paperwork" initiative and streamline, align, and focus on those measures that matter most for patient care and outcomes**. **We recommend leveraging existing solutions and datasets, while standardizing and streamlining data collection processes and ensuring consistency of definitions, categories and variables such as race and ethnicity across all federal programs to reduce administrative burden and enable clinicians to focus on patient care.** The MHA urges the CMS to develop support for providers for capturing, using, and exchanging information within and across service lines.

**The MHA urges the CMS to consider the following recommendations:**

- **Choose, adopt, and adequately incentivize the use of a single standard data set** that captures necessary and sufficient information on non-clinical patient characteristics. **This should be minimally burdensome to providers** and we recommend the adoption of standardized screening tools such as PRAPARE, AAFP's EveryONE project, or the CMS ACH Health-Related Social Needs screening tool, or the use of z-codes.

- **Distribute resources into community safety net programs to properly address social needs identified in data collection**. We urge the CMS to continue expanding the portfolio of programs and resources to support data analyses and quality improvement activities to bridge hospital-level efforts with post-acute and community-based programs and models to close health equity gaps due to lack of resources and accessibility to help strengthen the standardized collection of social needs data.

- **Expand disparity methods to include stratified results beyond current dual eligibility stratification since stratifying by dual eligibility status alone is not sufficient**. This is an easily accessible proxy measure that in no way captures the breadth of social determinants. We urge the CMS to include race and ethnicity, language preference, veteran status, health literacy, sexual orientation, and disability status which will enable a more comprehensive assessment of health equity to further identify and develop actionable strategies to promote health equity.

- **Reconsider creation of a facility equity score**: Although this is modeled from the Health Equity Summary Score (HESS) developed for the Medicare Advantage plans, the development of this score was virtually conceptual and not currently being utilized. By combining multiple measures and risk factors using output from the CMS disparity methods there would be a resulting "composite like" score. The M**HA believes a vague "composite-like" measure is not actionable or useful and cannot be feasibly and accurately calculated.**

- Consider a potential future measure regarding **organizational commitment to health equity.** We believe that consideration should be given to an attestation-based structural measure of a disparities impact statement (DIS) or organizational pledge that outlines how infrastructure supports the delivery of care that is equitable for all patient populations.

We believe that our recommended changes would result in a positive outcome for SNFs and the Medicare beneficiaries and all residents they serve. If you have any questions, please contact me at (517) 703-8608 or via email at vkunz@mha.org.

Sincerely,

Vickie R. Kunz
Senior Director, Health Finance