June X, 2023 - Comments Due June 5

The Honorable Chiquita Brooks-LaSure

Administrator

Centers for Medicare & Medicaid Services

Hubert H. Humphrey Building

200 Independence Avenue, S.W., Room 445-G

Washington, DC 20201

***RE: CMS-1779-P, Medicare Proposed Rule to Update the Skilled Nursing Facility Prospective Payment System for Fiscal Year (FY) 2024***

Dear Administrator Brooks-LaSure:

On behalf of its member hospitals, the Michigan Health & Hospital Association (MHA) appreciates this opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule to update the Medicare fee-for-service (FFS) prospective payment system (PPS) for Skilled Nursing Facilities (SNFs) for fiscal year (FY) 2024. When all proposed changes are considered, the rule is estimated to increase FFS payments to Michigan hospital-based SNFs by less than $500,000, or 3.4%, which fails to account for shortcomings in past market basket updates and the unprecedented financial strain health care providers in Michigan and across the United States (U.S.) continue to face. This also excludes the estimated impact of the 2% sequestration, estimated at roughly $300,000 annually through FY 2032.

Our specific comments regarding the FY 2024 proposed rule are below.

**Payment Update**

The CMS proposes a 6.1% annual market basket update, but this increase will be offset by the proposed negative 2.3% patient driven payment model (PDPM) parity adjustment, which is estimated to reduce SNF payments by $780 million nationally. As indicated above, when all proposed changes are considered, the rule is expected to increase SNF payments by only 3.4%, which is lower than the 4% increase in health care inflation for 2022 based on the U.S. Inflation Calculator. In addition, Medicare continues to pay less than the cost of providing care with the latest Medicare FFS margin data, indicating that, in total, Medicare payments cover only about 95% of the cost of care provided by hospitals.

Absent substantial financial support in the final rule, SNFs will struggle to continue providing these vital services in their communities, particularly as SNFs and other post-acute providers continue to face intense labor shortages and challenges. These staffing challenges impact the ability of inpatient hospitals to discharge patients in a timely manner, leading to increased expenses without commensurate revenue, higher length of stay and limited bed availability in the hospital setting. The MHA has long advocated that the right care be provided at the right time in the most appropriate care setting. **We urge the CMS to work with stakeholders to explore updates to the SNF market basket methodology, potentially with new proxies or alternative data. This will ensure the CMS can provide the most accurate and timely payment update to SNFs and avoid disruptions in the continuum of care for Medicare beneficiaries during this time when unprecedented inflationary increases are faced by SNFs and other providers.**

We also remain concerned about the proposed application of the 0.2% productivity cut for FY 2024. As with hospitals and other providers, SNF patients are provided time-intensive, hands-on skilled therapies and care. These types of services do not lend themselves to the proxy used by the CMS which is intended to capture new technologies, economies of scale, business acumen, managerial efficiencies and other changes in production**. The MHA urges the CMS to closely monitor the impact of such productivity adjustments and explore ways to use the agency’s authority to offset or waive these adjustments.**

**Wage Index Policies**

We continue to support the policy adopted for FY 2023 that implements a permanent 5% cap on any decrease to a provider’s wage index, relative to the prior year. **However, the MHA urges the CMS to implement this policy in a non-budget-neutral manner which would both stabilize provider reimbursement and avoid further unexpected reductions for other providers.**

**Civil Money Penalty Waiver of Hearing and Automatic Reduction of Penalty Amount**

The CMS proposes to allow a facility to waive their right to a hearing to contest a Civil Money Penalty and receive a corresponding reduction in the penalty amount without needing to submit such a request in writing. **The MHA supports this policy, which would reduce administrative burden for providers, while still allowing the opportunity to have penalty amounts reduced.**

**Proposed Updates to the SNF Quality Reporting Program (QRP)**

The Affordable Care Act requires that SNFs that do not successfully participate in the SNF Quality Reporting Program (QRP) are subject to a 2-percentage point reduction to the market basket update for the applicable year. In the FY 2024 proposed rule, the CMS proposes to adopt three new measures, modify an existing measure, and remove three measures. The CMS proposes to adopt three new measures for the SNF QRP and modify one measure:

***Adoption of Discharge Function Score Measure***

The CMS proposes to adopt an assessment-based outcome measure that estimates the percentage of SNF patients who meet or exceed an expected discharge score during the reporting period beginning with the FY 2025 SNF QRP. The observed discharge function score is calculated by summing individual function item values from the Minimum Data Set (MDS) at discharge. The expected discharge function score is calculated by risk-adjusting the observed score to control for patient characteristics including age, admission function score and clinical conditions. In other words, the score would be based on the individual patient’s characteristics and where they started in terms of function, how much improvement would be expected after their SNF stay.

The measure uses a statistical imputation approach to account for “missing” MDS elements when codes demonstrate that an “activity was not attempted”. In the event that an MDS item is coded as “not attempted”, the imputation approach inserts variables based on the value of other, non-missing items that are similar to the missing item resulting in the calculation making assumptions about what the patient would have scored on that item if it had been attempted based on their performance on other similar activities that were attempted.

The CMS proposes to begin publicly displaying data for this measure beginning with the September 2024 refresh of Care Compare, or as soon as technically feasible, using data collected from calendar year 2023. Displayed performance would be based on four quarters of data, updated quarterly**. The MHA opposes public reporting for this measure as it may inappropriately skew the decision-making process when patients and facilities are reviewing SNF performance prior to admission to a SNF.**

**The MHA urges the CMS to wait until this measure has undergone endorsement review by a concensus-based entity (CBE) and demonstrates that it gleans useful information for patients and providers before adopting it for use in the SNF QRP.**

***CoreQ Short-stay Discharge Measure***

The CMS proposes to adopt this measures that calculates the percentage of individuals discharged from a SNF who report being satisfied with their stay on the CoreQ questionnaire within 100 days of admission. SNFs would have to contract with an independent CMS-approved CoreQ survey vendor to administer the questionnaire and report the result to the CMS on behalf of the SNF. The questionnaire utilizes four items to calculate a score based on a 5-point Likert scale: Poor (1); Average (2); Good (3); Very Good (4); and Excellent (5):

1. In recommending this facility to your friends and family, how would you rate it overall?

2. Overall, how would you rate the staff?

3. How would you rate the care you received?

4. How would you rate how well your discharge needs were met?

The CMS would add two questions to determine whether to include or exclude the questionnaire based on who completed it—a SNF resident or someone else. The questions would read:

5. Did someone help you complete the survey?

6. How did that person help you?

The data would be collected by patient questionnaires that are commonly administered by third-party vendors and would capture all patients, regardless of payer. **The MHA requests that the CMS explore**

**options that would reduce measurement burden and healthcare operation costs related to collecting patient experience data.** Data collection is an important component in improving healthcare quality, but the MHA is concerned about the number of patient experience surveys and vendors a facility will need to contract with to satisfy all the data requirements required by the CMS. The CoreQ tool is not designed to give healthcare providers guidance to improve scores, nor does the tool provide individualized reports or real-time results. **The MHA encourages the CMS to explore other alternatives for collecting patient satisfaction information before adopting the CoreQ questionnaire for required collection to limit administrative burden and develop a measure that will deliver timely, accurate and actionable information.**

***Adoption of Percent of Patients/Residents Who Are Up to Date with COVID-19 Vaccination Measure***

The CMS proposes to adopt an assessment-based process measure beginning with the FY 2026 SNF QRP. This measure would report the percent of stays in which SNF patients are up to date on their COVID-19 vaccinations per the Centers for Disease Control and Prevention’s (CDC’s) latest guidance.

The CDC maintains different definitions of “up to date” and “fully vaccinated.” The public and hospital and post-acute care patients likely have a limited appreciation for the differences in these definitions and could easily misreport their vaccination status to facility staff when asked, giving the public a misleading picture of the vaccination levels of a facility’s patient population.

As shown in Michigan’s booster vaccine [data dashboard](https://www.michigan.gov/coronavirus/resources/covid-19-vaccine/covid-19-dashboard), vaccination administration rates can ebb and flow significantly based on factors outside the control of hospitals and other providers, including holidays, weather, vaccine/pharmaceutical supply chain management, staff availability and more. The frequency and speed with which these rates change will not accurately depict the vaccination rate of a facility’s patients *or* staff.

Only 7.9% of individuals in the U.S. experience an overnight hospital stay annually. While hospitals support doing education of vaccinations during patient encounters, hospitals’ ability to interact with and influence a statistically significant number of patients who are not up to date on their COVID-19 vaccinations is very limited. Moreover, with extreme staffing shortages plaguing our emergency departments, the resources to spend additional time gathering COVID-19 vaccine data, administering the vaccine, or doing extensive education on vaccination are limited.

The CDC confirms the following: “Adolescents and adults in rural areas had a much lower primary series completion rate and up-to-date vaccination coverage. Bivalent booster coverage was lower among non-Hispanic Black or African American (Black) and Hispanic or Latino (Hispanic) adolescents and adults compared with non-Hispanic White (White) adolescents and adults. Among adults who were open to receiving booster vaccination, 58.9% reported not having received a provider recommendation for booster vaccination, 16.9% had safety concerns, and 4.4% reported difficulty getting a booster vaccine.” Hospitals fully support promoting vaccines among all populations, including at community-centered locations and through trusted community partners, in addition to hospital-operated facilities. However, these continuing disparities in vaccine uptake reflect not on the local hospital’s efforts to vaccine their patients, but often in differences deeply rooted in culture, religion, ethnicity, socioeconomic status and more. These disparities should not be a measure associated with a hospital or an indicator to a potential patient of the safety of that hospital’s environment; rather, they should be used to guide all vaccine advocates’ efforts to increase vaccination rates in their communities.

**The MHA requests the CMS to withdraw this proposal.**

***Modification of the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP COVID-19 Vaccine) Measure***

Beginning with the FY 2025 SNF QRP, the CMS proposes to modify the existing Healthcare Personnel (HCP) COVID-19 Vaccination measure used in the SNF QRP. The current measure assesses the number of HCP who have received a complete vaccination course against COVID-19. In this rule, the CMS proposes to replace the definition of “complete vaccination course” with a definition of “up to date” with the CDC recommended COVID-19 vaccines. The CMS proposes this modification to incorporate new CDC guidance related to booster doses and their associated timeframes.

The MHA supports vaccination as a means of keeping both staff and patients safe but have concerns regarding this measure. The CDC maintains guidance that receiving a dose of COVID-19 vaccine may or should be delayed if a person has or has recently had COVID-19 infection. This could impact the timing of an employee’s vaccine dosage, resulting in an inaccurate reporting of employees “up to date” on vaccination.

As mentioned above, disparities remain in different geographic areas, among races and more. These same disparities tend to exist within the healthcare workforce. Therefore, while hospitals and post-acute care facilities will continue to educate and encourage all employees to be vaccinated against COVID-19 to protect themselves and patients, challenges remain to overcome historical challenges and should not be measured against a hospital’s ability to provide a safe environment. **The MHA opposes the proposed modification to the HCP measure and urges the CMS to not finalize the modified measure**.

**Proposed Increase in Data Completion Thresholds**

The CMS proposes to require SNFs to report 100% of the required quality measure data and standardized assessment data collected using the MDS tool on at least 90% of assessments submitted to the CMS. SNFs that fail to meet this requirement would be subject to a 2-percentage point reduction to their applicable annual payment update. Currently, SNF are required to report 100% of the data on 80% of MDSs. The CMS states that the agency needs more complete data to ensure validity and reliability of the SNF QRP, and that this proposal would further align data completion threshold across post-acute settings. The CMS also indicated that the majority of SNFs are already in compliance with or exceeding the proposed threshold.

**The MHA appreciate that the majority of SNFs currently comply with or exceed the proposed 90% threshold but oppose adoption of this proposal and urge the CMS to maintain the current 80% threshold.**

**Summary**

The MHA appreciates this opportunity to provide comments to the CMS on the FY 2024 SNF proposed rule and believe that our proposed changes will have a positive impact on SNFs and all patients they serve. If you have questions regarding this comment letter, please contact me at (517) 703-8608 or via email at [vkunz@mha.org](mailto:vkunz@mha.org).

Sincerely,

Vickie R. Kunz

Senior Director, Health Finance