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Advancing Health in America

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May 24, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1802-P, P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: 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 2025; 89 Fed. Reg. 23,234 (April 3, 2024).

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 500 skilled-nursing facilities (SNFs), and our clinician partners — more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2025 SNF prospective payment system (PPS) proposed rule.

SNFs play a critical role in the continuum of care, particularly for many hospitalized patients. For example, as AHA highlighted in last year's rulemaking, hospitals have faced increasing difficulty discharging patients to post-acute care, including SNFs. This challenge has largely been due to staffing shortages and associated reduced capacity of SNFs and other providers. These shortfalls then place additional burden back on hospitals, including the need for hospitals to board patients until a discharge location can be found. Therefore, it is vital for the entire continuum of care that SNFs are properly resourced.

As such, AHA is concerned that CMS' payment updates, in addition to increased requirements on SNFs, will exacerbate their, as well as hospitals', financial

difficulties. **Therefore, we request that CMS more closely examine its process for forecasting and providing market basket updates.** This is especially true for hospital-based SNFs, which care for a distinct patient population that is more resource-intensive.

PROPOSED FY 2025 MARKET BASKET UPDATES

CMS is proposing a net update for SNFs in FY 2025 of 4.1%. This includes a market basket adjustment of 2.8% less a productivity cut of 0.4 percentage points, as well as a FY 2023 market basket forecast error adjustment of 1.7% percentage points. AHA supports the positive update for SNFs, including the forecast error adjustment. However, we have ongoing concerns about both missed forecasts as well as the market basket not appropriately capturing inflation. **As such, the AHA urges CMS to reevaluate its approach to market basket updates and consider changes.**

Along with all health care facilities, SNFs have faced unprecedented inflation in recent years. A recent report from the AHA finds that hospital employee compensation has grown by 45% since 2014, which is notably higher than general inflation.[1] Labor-related inflation has been driven in large part by a severe workforce shortage, which the Department of Health and Human Services (HHS) says will persist well into the future.[2] Because of this, providers are turning to pricey contract labor to sustain operations. Indeed, hospital contract labor costs increased by 258% from 2019 through 2023.[3] These increases are of a similar magnitude for SNFs, as hospitals and SNFs utilize similar personnel — including nurses and therapists. In addition, hospital-based SNFs do, in fact, share the same costs as part of their integrated operations.

Drug and supply costs also have pressured providers due to disruptions in the supply chain and other factors. In fact, HHS found that prices for nearly 2,000 drugs increased an average of 15.2% from 2017 through 2023, notably faster than the rate of general inflation.[4] Further, the American Society of Health System Pharmacists has found that numerous drug shortages are having a critically negative impact on operations.[5] Again, while these figures examined hospitals, SNFs share many of these same supply issues.

All of these escalating costs for essential clinicians, drugs, supplies and other items have put a strain on the entire health care continuum. In all, Kaufman Hall found that

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[1] https://www.aha.org/system/files/media/file/2024/05/Americas-Hospitals-and-Health-Systems-Continue-to-Face-Escalating-Operational-Costs-and-Economic-Pressures.pdf
[2] ASPE Office of Health Policy, *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13 at 1 (May 3, 2022).
[3] Syntellis and AHA, *Hospital Vitals: Financial and Operational Trends* at 2 (last visited May 8, 2023), https://www.syntellis.com/sites/default/files/2023-03/AHA%20Q2_Feb%202023.pdf.
[4] ASPE. (Oct. 2023). Changes in the List Prices of Prescription Drugs, 2017-2023. https://aspe.hhs.gov/reports/changes-list-prices-prescription-drugs
[5] https://news.ashp.org/-/media/assets/drug-shortages/docs/ASHP-2023-Drug-Shortages-Survey-Report.pdf

overall expenses have risen 18% for hospitals compared to 2021.[6] While hospitals and SNFs do not have the exact same mix of costs, there is a large degree of overlap, and these pains are shared across all provider types.

Despite escalating cost pressures, market basket updates have now shown a consistent pattern of not only failing to accurately forecast but also to eventually capture cost growth. Since the COVID-19 public health emergency (PHE), IHS Global Insight Inc. (IGI's) forecasted growth for the SNF market basket has shown a consistent trend of under-forecasting actual market basket growth. Indeed, there has now been four consecutive years (FY 2021-2024) of under-forecasts. AHA is cognizant of the fact that forecasts will always be imperfect, but in the past, they have been more balanced.

Under statute, SNFs receive forecast error adjustments. However, this mitigates some, but not all, of the potential disruptions due to under-forecasts. As CMS knows, the forecast error adjustments are made two years after the year in question. SNFs must therefore contend with the underpayment for two entire years before it is reconciled, which can put serious strains on their operations. It also can hamper their ability to make investments into their facilities and workforce. Timely, adequate funding is particularly crucial now that CMS is moving forward with its new minimum staffing requirements, which does not include a corresponding payment adjustment.

In addition, we are concerned that four straight years of under-forecasts indicates a more systemic issue with IGI's forecasting. As explained above, there has been large growth in provider costs in the last several years, exceeding general inflation, which totaled 16.8% from 2021 to 2023 according to the CPI-U.[7] However, actual SNF market basket growth (not forecasts) totaled only 15.5% during this time period. Given the labor-shortage and labor-intensive nature of SNFs, as well as the rise in other medical costs, AHA is doubtful that SNF costs grew less than general inflation.

As we have explained to CMS previously, SNFs also play a critical role in hospital operations. Hospitals across the country partner with SNFs in their community to provide post-hospital care and ensure a safe transition for patients out of the hospital. Restricted funding and other disruptions can therefore put additional strain on hospitals, who are increasingly required to board patients past their optimal discharge date until appropriate post-acute care can be found. Further, hospital-based SNFs care for distinctly more-acute and costly patients, as demonstrated by their sharply negative margins.[8] Therefore, under payments impact these providers even more, as they are already paid notably below cost.

As such, we urge CMS to reevaluate its approach to market basket updates and consider changes. AHA supports CMS' decision to rebase the SNF market basket one

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[6] https://www.kaufmanhall.com/sites/default/files/2024-05/KH-NHFR_2024-04.pdf
[7] https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexannualandsemiannual_table.htm
[8] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_Ch6_MedPAC_Report_To_Congress_SEC.pdf

year earlier than is typical. This rebasing may help capture some of this additional cost growth. However, AHA believes additional steps are likely needed. This could include a closer examination of the proxies used for the market basket, among other areas. Ensuring that both the forecasts and actual updates to the market basket are accurate will minimize disruptions in care for both hospital and SNF patients. AHA would be happy to assist CMS in these efforts.

Finally, the AHA continues to be concerned about CMS' proposed application of a 0.4% productivity cut for FY 2025. As with hospitals, 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 CMS, which is intended to capture new technologies, economies of scale, business acumen, managerial efficiencies and other changes in production. The AHA, therefore, urges CMS to closely monitor the effects of such productivity adjustments and explore ways to use its authority to offset or waive these adjustments.

Wage Index Policies

CMS proposes to apply to the wage index the most recent labor market areas issued by the Office of Management and Budget in the July 2023 Bulletin No. 23-01. As CMS states in the proposed rule, this would result in wage index decreases for 43% of SNFs. CMS does not propose a specific policy to address this, and instead intends to rely on its existing policy of applying a 5% year-to-year cap on any reductions in an individual SNF's wage index.

AHA continues to support the existing 5% cap policy. However, we are concerned about the divergent impacts this has on different providers. For example, the wage index changes would result in a 1% overall reduction for urban hospital-based SNFs. Therefore, the total update for these SNFs would effectively be only 3.2%. While the 5% cap would help smooth these reductions, they will nonetheless be a large challenge when fully implemented. AHA requests that CMS examine this issue and consider adjustments, including potentially implementing the cap on wage index adjustments in a non-budget neutral manner.

SNF QUALITY REPORTING PROGRAM

Proposed Adoption of Four New Standardized Patient Assessment Data Elements. Beginning with the FY 2027 SNF Quality Reporting Program (QRP), CMS proposes to require SNFs to report four new standardized patient assessment data elements (SPADEs) under the social determinants of health (SDOH) domain. In its proposal, CMS states that the new SPADEs address health-related social needs (HRSN) not already captured by the existing SDOH elements and include food security, living situation and utility difficulties. The AHA shares CMS' goal of advancing health equity and recognizes the value that screening for HRSNs can play in identifying barriers to achieving the best outcomes for all patients. However, we are concerned that

the proposed new SPADEs are not well-aligned with similar HRSN reporting requirements across the care continuum. We also believe the proposed SPADEs need further testing and refinement to ensure they work as intended in the SNF setting.

In its proposal, CMS states that it believes these new requirements would "further standardized the screening of SDOH across quality programs," citing the recently adopted quality measures in the Inpatient Prospective Payment System Quality Reporting (IQR) and Inpatient Psychiatric Quality Reporting Program (IPFQR) that assess whether facilities have screened patients for housing instability, food insecurity, utility difficulties, transportation needs and interpersonal safety. Indeed, CMS states that it believes "using common standards and definitions for new items is important to promote interoperable exchange of longitudinal information between SNFs and other providers to facilitate coordinated care, continuity in care planning, and the discharge planning process."

While the proposed SPADEs do address some (but not all, like interpersonal safety) of the same HRSNs addressed by the screening measures, the proposed requirements are hardly standardized with those in the IQR and IPFQR. The proposed SPADEs are adapted from the Accountable Health Communities (AHC) HRSN Screening Tool developed for the AHC model; CMS is dictating precisely when and how (that is, asking questions with specific wording during the initial admission assessment) SNFs are to assess patients for these HRSNs. However, inpatient acute care hospitals and psychiatric facilities may use any "standardized HRSN screening" and are only asked to document that a patient was screened, not when or how. In other words, these proposals are unlikely to produce the interoperable data CMS apparently believes they will.

Further, the AHA raises some concerns with the elements themselves. In implementing the AHC HRSN screening tool in the AHC model, CMS directs users to follow particular protocols to determine a patient's eligibility for completing the tool, select domains for use in their communities, and score patient responses to determine next steps. In this proposed rule, CMS merely picks a few questions from the tool and plants them in the MDS without much guidance. The AHA is concerned that it will be challenging to glean accurate responses to the AHC items from the SNF patient population in particular, considering that SNF patients and residents are generally more ill than the average Medicare beneficiary for which the screening tool was developed. For example, the food security questions ask patients to rate the frequency of food shortages using a three-point scale, whereas other questions on the MDS, such as the resident mood (PHQ-9 tool), behavioral symptoms and daily preferences items, use a four-point scale to determine frequency. These discrepancies might make it difficult for staff to administer the SPADEs and given the inconsistency with the scales used in other MDS items, it may lead to confusion for staff and patients alike. In addition, there is no skip logic included for these questions as there are for other MDS items. If a patient reports that they do not have a stable place to live in response to the living situation item, it seems inappropriate to subsequently ask them about their utility difficulties.

Overall, the AHA questions the utility of including these items in the MDS. While we agree that SNFs — and other health care facilities and providers — should consider their patients' and residents' HRSN in their care, CMS' evaluation of the use of the AHC HRSN screening tool in the model showed that it "did not appear to increase beneficiaries' connection to community services or HRSN resolution." At a minimum, we believe the proposed new SPADEs need further testing and clearer implementation guidance before CMS adopts them for the SNF QRP.

Lastly, we also request that CMS articulate its vision of how HRSN information collected in the SPADEs will be used in its quality and payment programs. While CMS appears to be focused for now on HRSN screening, there is evidence that CMS is considering even farther-reaching approaches to holding SNFs and other health care providers accountable for addressing HRSNs. For example, CMS is also considering measures that assess connections to community providers and the resolution of HRSNs following care. We believe that those measures would inappropriately hold SNFs and other health care providers solely accountable for social drivers of health that require resources and engagement across an entire community to address. We are concerned that CMS may implement such measures in the SNF QRP in the future, using its SPADE collection process as the mechanism to collect measure data. Holding SNFs solely accountable for community-based outcomes is far outside the scope of these facilities.

Proposed QRP Data Validation Process. The Consolidated Appropriations Act of 2021 directed CMS to implement a validation process for data submitted under the SNF QRP. Specifically, CMS would validate claims-based measures by using the same process used by Medicare Administrative Contractors to validate claims for medical necessity using pre- and post-payment audits. **The AHA questions how a process to validate claims for medical necessity is analogous to validating data for accuracy in quality reporting and requests further clarification from the agency.**

Proposed Patient Safety Enforcement Authority Changes. CMS proposes to amend regulatory language to expand its ability to impose both per-instance and per-day civil monetary penalties (CMPs) on facilities found to have multiple types of patient safety deficiencies. **The AHA agrees with CMS' rationale to more closely align the imposition of CMPs with the character of noncompliance** as the current regulations result in variation of penalties based on survey timing rather than severity or extent of harm. As always, we encourage the agency to provide clear and actionable information along with their findings of deficiencies to ensure that facilities are equipped to correct those instances of noncompliance in an effective and efficient way that does not further threaten patient safety or access to care. In addition, we urge CMS to be thoughtful and consistent with the type of information sources upon which they rely for retrospective review; for example, weighing review of medical charts or written policy more than interviews with staff and residents, especially those who may not have been present at the facility at the time the deficiency began.

While SNFs should certainly be held accountable for deficiencies in patient care, **the proposal to expand CMS' authority to increase financial penalties via the survey process is not by itself sufficient to encourage improvement in quality of care.** Survey findings can vary significantly regardless of the actual instances of noncompliance — even in its own words in this proposed rule, CMS "found national variations in the length of time PD CMPs are imposed based on when the noncompliance occurred, when the survey was performed, and when the facility was found to have corrected the noncompliance" rather than the extent or severity of harm (or potential for harm). Facilities can work with CMS and state surveyors to explain, defend and amend deficiencies; however, some facilities (particularly small and rural SNFs) lack the same resources to do so. We are concerned that simply increasing potential financial penalties without other types of support (especially considering the SNF Value-based Purchasing program is not a budget-neutral financial incentive tied to quality and thus results in negative payment adjustments for a significant proportion of SNF participants) will result in outsized disadvantages to smaller organizations.

Finally, we hope that CMS will consider how this expanded enforcement authority will interact with recently or to-be-finalized requirements, such as the minimum staffing requirements for long-term care facilities. The agency has not yet provided interpretive guidance for how it will survey against the staffing requirements, and thus it will be unreasonable to hold SNFs accountable in two years when compliance is required with penalties proposed in a rule before standards for those requirements are available.

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The AHA appreciates your consideration of these issues. Please contact me if you have questions, or feel free to have a member of your team contact Jonathan Gold, AHA's senior associate director for policy, at (202) 626-2368 or jgold@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development