American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

June 5, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1779–P
Mail Stop C4–26–05
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 2024; 88 Fed. Reg. 21,316 (April 10, 2023).

Dear Administrator Brooks-LaSure:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 700 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) 2024 SNF prospective payment system (PPS) proposed rule.

The COVID-19 public health emergency (PHE) ended May 11, 2023; however, this does not mean that the health care system has returned to "pre-COVID" operations. Especially in the case of hospital continuum of care, of which SNFs are an important part, the health care system continues to reel from the effects of the pandemic and the extraordinary inflationary environment. Challenges facing the field include skyrocketing labor-costs, critical staffing shortages, and unprecedented rises in supply and drug costs. These have been felt by all providers, including hospital based and freestanding SNFs.

The AHA would like to stress to CMS the importance of SNFs' role in the continuum of care, including on hospitals' ability to properly care for and safely

discharge patients in a timely manner. As SNFs and other post-acute providers have been strained by the pandemic, the ripple effects have been felt throughout the continuum of care. For example, a December 2022 report from AHA showed that the average length of stay (ALOS) for patients awaiting discharge to a SNF rose by more than 20% from 2019 to 2022.[1] This increase is driven in large part by the difficulties SNFs and other post-acute providers have had in staffing and operating at full capacity. This, in turn, has limited hospitals' capacity as hospital beds and resources remain dedicated to patients awaiting post-acute placement. **Therefore, its vital to the entire health care continuum that CMS provide adequate reimbursement and resources to SNFs to help ensure all patients receive timely, appropriate care.**

The AHA also would like to call out the unique experience and role played by hospital based SNFs during the PHE, which in some ways was notably different than their freestanding counterparts. Hospital-based SNFs' connection to their host hospitals facilitated more robust infection control, improved access to personal protective equipment and other factors that affected their overall PHE response. That said, hospital based SNFs also faced immense challenges with each surge of the pandemic and its after-effects, including skyrocketing labor and supply costs, as well as acute labor shortages. Therefore, as CMS considers how to ensure SNFs are adequately resourced to care for Medicare beneficiaries, we ask that the agency pay special attention to these hospital based SNFs.

Proposed FY 2024 Payment Update

CMS is proposing a net estimated increase in SNF PPS payments of 3.7%, or $1.2 billion relative to FY 2023. This includes a market basket adjustment of 2.7% adjusted by a productivity cut of 0.2 percentage points, a FY 2022 market basket forecast error adjustment of 3.6 percentage points, and a cut of 2.3 percentage points related to implementation of the Patient-driven Payment Model. AHA is appreciative of the net positive update, particularly the positive forecast error adjustment. However, we remain concerned that CMS' market basket approach continues to show lags in recognizing inflationary trends and may not fully capture the rising costs of care.

The most recent analysis from Kaufman Hall in its *National Hospital Flash Report* indicates that from 2020 to present, overall expenses have risen by 18% for hospitals.[2] Although SNFs have a different mix of goods and services, many of the key components of both market baskets are the same, such as

---

[1] AHA, *Issue Brief: Patients and Providers Faced with Increasing Delays in Timely Discharges*; December 2022 (https://www.aha.org/system/files/media/file/2022/12/Issue-Brief-Patients-and-Providers-Faced-with-Increasing-Delays-in-Timely-Discharges.pdf).
[2] Kaufman Hall, *National Hospital Flash Report* (April 2023) https://www.kaufmanhall.com/sites/default/files/2023-05/KH-NHFR_2023-04.pdf

heavy reliance on nurses, therapists and other clinicians, as well as medical supplies. Indeed, much of the increase in cost has been driven by labor, including contract labor costs, which have risen 258% since 2019.[3] In addition, this study showed medical supply costs per patient have risen 18.5% from 2019 through 2022. Drugs, and especially specialized drugs, make up a large portion of this increase, with a Department of Health and Human Services (HHS) study finding that many commonly used drugs have had their price increase by more than 30% in recent years.[4] Further, HHS has found that health care workforce shortages will persist well into the future.[5]

Despite these double- and triple-digit rising costs, the market basket updates for SNFs have been in the low single digits: 2.2% in FY 2021, 2.0% in FY 2022 and 3.6% in FY 2023. Although CMS provides forecast error adjustments to "true-up" differences in the forecasted and actual market baskets, these adjustments come two years later, which could seriously strain providers in the interim. In addition, they still may not accurately capture rising costs for SNFs, as has become evident as hospitals find it increasingly difficult to discharge patients to SNFs as they strain to operate at maximum capacity. **Therefore, the AHA encourages CMS to work with stakeholders to explore updates to the SNF market basket methodology, potentially with new proxies or alternative data. This will ensure CMS can provide the most accurate and timely payment update to SNFs and avoid disruptions in the continuum of care for Medicare beneficiaries.**

The AHA also continues to be concerned about CMS' proposed application of a 0.2% productivity cut for FY 2024. 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

The AHA continues to support the policy finalized last year that implements a permanent 5.0% cap on any decrease to a provider's wage index, relative to the prior year. **That said, we urge the agency to implement the change in a non-budget-neutral**

---

[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] Arielle Bosworth, et al., Assistant Secretary for Planning and Evaluation, Price Increases for Prescription Drugs, 2016-2022, HP-2022-27 at 1 (Sep. 30, 2022),
[5] 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).

manner. Doing so would both stabilize providers' reimbursement and avoid further unexpected reductions for other providers.

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

CMS proposes to allow for 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 AHA supports this policy, which would reduce administrative burden for providers, while still allowing the opportunity to have penalty amounts reduced.**

SNF Quality Reporting Program (QRP)

Modified COVID-19 Vaccination Coverage among Health Care Personnel (HCP) Measure. The AHA strongly supports the vaccination of health care personnel and communities against COVID-19. We also agree with CMS' rationale underlying the proposal to adopt this modified measure that measures in use in its quality reporting programs should reflect the current science.

However, the evidence around the optimal cadence for booster doses of COVID-19 vaccination, as well as the seasonality of the virus itself is evolving rapidly. Over the past several months, the Centers for Disease Control & Prevention (CDC) and the Food and Drug Administration (FDA) have indicated that they are considering the adoption of a once-yearly regimen for COVID-19 vaccinations comparable to the well-established approach used for influenza vaccination. In addition, the AHA is concerned that the administrative complexity of collecting CDC's current definition of "up-to-date" status may outweigh its benefit. For these reasons, **we recommend CMS continue to collect up-to-date vaccination status on a voluntary basis and implement required reporting of up-to-date status after FDA and CDC have completed their recommendations on an updated vaccination schedule.**

We encourage CMS to learn from the experience of implementing the previous version of this measure and consider the foreseeable logistical challenges of data collection and reporting when considering this new version for inclusion in its various quality reporting programs. As CMS notes in the proposed rule, health care facilities are collecting and reporting data on "up-to-date" COVID-19 vaccination status on a voluntary basis. However, facilities have reported that this collection process is quite administratively burdensome under CDC's current "up-to-date" definition. This is because the collection protocol uses a reference time-period for determining up-to-date status that changes every quarter. Practically speaking, this means that a HCP who counted as "up-to-date" in a given quarter may no longer be up-to-date in the next quarter. Furthermore, CDC's vaccination guidance suggests that some individuals with certain risk factors should consider receiving an additional booster dose within four months of receiving their first

bivalent dose. Yet, hospitals usually do not have routine access to data to know which of their HCPs may need an additional booster. In fact, collecting accurate data on HCPs underlying risk factors likely would require hospitals to both obtain permission to have such data, and a mechanism to keep the data fully secure. The AHA is concerned that the resource intensiveness of collecting data under CDC's current definitions may outweigh its value.

The AHA believes that the adoption of a once-yearly vaccination regime would alleviate much of the administrative complexity of collecting up-to-date vaccination status. While we do not yet know the precise timing, recent discussions from the FDA and CDC's vaccination advisory committees, as well as public statements from the agencies and White House, suggests that such a schedule could be adopted as soon as fall 2023. By delaying the required reporting of "up-to-date" vaccination status, CMS could align its reporting requirements around this more efficient approach. In practical terms, we believe the soonest facilities could report up-to-date status based on a once-yearly vaccination regimen is the second quarter of 2024, but we recognize that more time may be needed.

As CMS continues to implement the HCP COVID-19 vaccination measure across its programs, we also urge the agency to consider other important implementation issues. For example, we continue to urge that CMS get the measure endorsed by a consensus-based entity (CBE). A CBE endorsement process will enable a full evaluation of a range of issues affecting measure reliability, accuracy and feasibility. Given the urgency of addressing the COVID-19 pandemic, the current version of the measure never went through a CBE endorsement process and is relatively new to the CMS quality reporting programs. As a result, we have not yet had a holistic evaluation regarding whether the measure is working as intended (e.g., reflecting vaccination rates accurately, achieving CMS' stated goals of encouraging vaccination).

Finally, CMS needs to consider how to implement this measure in a way that is consistent and logical with other sources of information regarding vaccination among HCP. The time lag between data collection and the publicly reported rate will result in a mismatch between the true rate of HCP who are up to date with their vaccinations and the rate that is displayed on Care Compare; CMS needs to clearly communicate what publicly reported data reflects.

Discharge Function Score Measure & Removal of Overlapping Discharge Function Measures. CMS proposes to adopt this 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; in other rules, the agency proposes to adopt the same measure in the inpatient rehabilitation facility (IRF) and long-term care hospital (LTCH) QRPs as well. While this cross-setting discharge function score measure appears to fulfill requirements of the IMPACT Act better than the current, setting-specific self-care and mobility discharge score measures used in the SNF, LTCH and IRF QRPs (which CMS proposes to remove in this same

rule), we continue to doubt the cross-setting applicability of this measure considering the different patient populations served by the various post-acute care settings. **We urge CMS to wait until this measure has undergone endorsement review by a consensus-based entity (CBE) and demonstrates that it gleans useful information for patients and providers before adopting it for use in the SNF QRP.**

The measure uses information from Section GG items that appear on all four of the patient assessment instruments across the various post-acute care settings. While patients are assessed using the same or similar items, the capabilities and goals of patients differ widely by setting. The measure developer notes that the measure is risk adjusted and calculated individually by setting; then, the calculation for measure performance "rolls up" information from several items to calculate an overarching score. Risk adjustment takes many variables into account, and denominators vary by setting. For example, the denominator for the measure when calculated in the LTCH QRP includes all patients regardless of payer, while for the SNF QRP the denominator consists of patients/residents under Medicare fee-for-service.

While we appreciate the work the developer has done to attempt to consider the myriad of differences in patient populations across the various settings—including demographics, case mix, severity of illness, length of stay and comorbidities—at some point these variables alter the underlying calculation of the cross-setting measure and result in four different measures. In other words, discharge function is calculated in a way that is not truly standardized, as the IMPACT Act intended. Is it necessary to force a measure that is "cross-setting" in name only into CMS quality programs? Perhaps if testing of the measure demonstrates that this measure produces statistically meaningful information that can be used to inform improvements in care processes, it is. But until we have that information from the endorsement review process by a CBE, the AHA has serious doubts about the utility of this measure.

In addition, the measure uses a statistical imputation approach to account for "missing" assessment elements when codes on the assessments note that the "activity was not attempted" (ANA). If an assessor codes an item as "not attempted," the imputation approach inserts variables based on the values of other activities that were completed; in other words, the calculation makes 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. CMS argues that this approach "increases precision and accuracy and reduces the bias in estimates of missing item values." While we understand that scores would be influenced more heavily by individual assessment items if there are fewer included in the calculation, CMS errs in labeling items coded ANA as "missing." When an activity is not attempted, it is likely because it would be clinical inappropriate or dangerous for a patient to attempt it; for example, it would be ill-advised (and painful) for a patient with a healing wound on one side to roll left to right. In such a case, making assumptions about the patient's function based on other activities would, in fact, not improve the precision of the score.

We also question whether it is precise and accurate to generically apply an "expected" discharge score based on statistical regressions to unique patient populations, and whether the comparison of observed to "expected" function could wholly be attributed to the facility's quality of care. The calculation approach for the "expected" discharge score is opaque, which makes it difficult for providers to know what they're working towards. In reality, providers strive to help each individual achieve his or her own specific goals related to function, independence and overall health. These goals are not based on statistical regressions.

The AHA understands the purpose of this measure and agrees that the discharge function measures currently in use in the SNF QRP (Application of IRF Function Outcome Measures: Change in Self-Care Score for Medical Rehabilitation Patients, Change in Mobility Score for Medical Rehabilitation Patients, and Application of Percent of Long-term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function) do not meaningfully evaluate comparative performance across post-acute care settings. However, without further testing and review of the proposed Discharge Score measure by a CBE, we are uncertain that this measure brings value to the QRP and thus cannot support it for adoption.

Percent of Patients/Residents who are Up to Date with COVID-19 Vaccination Measure. Beginning with the FY 2026 SNF QRP, CMS proposes to adopt this assessment-based process measure that reports the percentage of stays in which patients/residents in a SNF are up to date with their COVID-19 vaccinations per the CDC's latest guidance. The agency reasons that the measure would, when publicly reported, provide useful information for patients and their caregivers when choosing a facility, and "would be an indirect measure of SNF action" since the SNF would, according to CMS, have the opportunity to administer the vaccine to patients during their stay, coordinate a follow-up visit for the patient to obtain the vaccine at their physician's office or local pharmacy, or educate the patient about the importance of staying up-to-date with vaccinations. CMS also proposes to adopt this measure for the LTCH and IRF QRPs in their respective rules.

The AHA strongly supports the vaccination of health care providers and communities for COVID-19 and acknowledges the importance of up-to-date vaccinations. However, this measure has not been tested for validity and reliability, and thus, we cannot support it without knowing that it is, at minimum, feasible to report and likely to produce statistically meaningful information. Furthermore, we doubt that the conceptual construction of the measure is the best way to encourage vaccination, especially in post-acute settings where care is delivered in episodic rather than longitudinal fashion. When reviewed by the National Quality Forum (NQF)'s Measure Applications Partnership (MAP) during the 2022-2023 review cycle, the Post-acute/Long-term Care Workgroup voted "Do Not Support" for this measure, meaning that a multi-stakeholder panel of experts representing providers, patients and payers do not support this measure for inclusion in the SNF QRP.

Vaccination status among patients/residents is subject to many patient-level factors outside of the control of providers. For post-acute facilities and providers, it may be infeasible or inappropriate to offer vaccination for patients due to length of stay, ability to manage side effects and medical contraindications, or other logistical challenges to gathering information from a patient who may have received care from multiple proximal providers. Even without these challenges, however, patients/residents may choose to forgo vaccination despite a provider's best efforts. It is possible that a post-acute care facility could have a robust effort to encourage vaccination among their patients/residents, but still have a relatively low rate of vaccination. As the Health Equity subcommittee of the NQF MAP noted in its review of this measure, cultural norms often play a large role in vaccine confidence. While post-acute providers will always seek to counsel vaccination in a culturally sensitive way, they also want to honor the choice of their patients once they have offered their clinical advice.

We reiterate that we understand the importance of vaccination in protecting patients from the most serious outcomes of COVID-19. However, it is unclear whether the use of this measure will produce those results, or if it is feasible for post-acute care facilities to collect and report the information necessary. The measure consists of a single yes or no item on the LCDS without any requirements for documentation or validation of vaccination status. While we acknowledge that additional documentation would be unduly burdensome for providers to collect, without it the measure is a mere checkmark in a box with no evidence that it leads to improved quality of care (since, as stated above, the measure has not been fully tested). For these reasons, **we do not support the adoption of this measure in the SNF QRP.** CMS also may want to consider whether alternative measure constructions focused on the actions providers take in encouraging vaccination might be better suited to achieving the goal of higher vaccination rates.

CoreQ: Short-stay Discharge Measure. Beginning with the FY 2026 SNF QRP, CMS proposes to adopt this measure that calculates the percentage of individuals discharged in a six-month period from a SNF, within 100 days of admission, who are satisfied with their SNF stay. Specifically, it calculates the number of individuals who have an average satisfaction score on a five-point Likert scale of greater than or equal to three for the four questions on the CoreQ patient satisfaction questionnaire. The questionnaire is administered by customer satisfaction vendors.

The AHA appreciates CMS' approach to considering the best way of capturing patient satisfaction in SNFs. While it is vital to collect information on patient experience in SNFs, the CoreQ measure is not ready to be proposed for inclusion in the SNF QRP due to substantial logistical concerns that answers to the RFI in this rule may help elucidate. For example, the CoreQ questionnaire is a proprietary tool and thus requires administration by third-party vendors (as opposed to a Consumer Assessment of Healthcare Providers and Systems, or CAHPS, survey, which is maintained by the U.S. Agency for Healthcare Research and Quality). This raises questions about the burden

of working with these vendors, including the cost. It is also unclear who will bear responsibility for transmittal, storage and quality assurance of the data collected. We encourage CMS to consider additional approaches to collecting patient satisfaction information before proposing the CoreQ questionnaire for required collection; just because the tool is available now does not mean that it is the best option to collect and analyze this important data.

Increase in Data Completion Thresholds. Beginning with the FY 2026 SNF QRP, 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 CMS, an increase from the current threshold of 80%. If a SNF does not meet this requirement, it would be subject to the 2-percentage point reduction to its FY annual payment update. CMS reasons that it needs more complete data to ensure the validity and reliability of the SNF QRP, and states that its data show that the majority of SNFs are already meeting or exceeding the proposed threshold.

While we understand CMS' desire to have "more complete data," we do not believe that this proposal will achieve that objective. First, the idea behind allowing for 20% of the assessments to be incomplete is to accommodate those instances in which it is not possible to complete the assessment for clinical reasons, such as when patients are discharged or transferred to an acute care hospital under emergency circumstances. In such cases, it would be inappropriate to stop the emergency discharge or transfer process to undertake a skin assessment of the patient, for example, and the assessment would be deemed incomplete. For facilities that serve larger proportions of complex and/or acutely ill patients, these cases are more frequent and that 20% buffer is necessary. Increasing the threshold to 90% would put these facilities that have otherwise been in compliance with the reporting requirements at a serious disadvantage.

Second, CMS argues that its proposal would not be overly burdensome to providers because so many of them already meet or exceed the 90% threshold. These providers clearly do not need the motivation of a higher threshold to report a larger proportion of complete assessments, so CMS' proposal would be moot. For those who are reporting at least 80% complete assessments, the increased threshold would put unnecessary pressure to complete the extremely lengthy and time-consuming LCDS, potentially negatively affecting the accuracy of the data—using the same example of the patient being emergently transferred to acute care, an assessor might feel the need to perform a cursory skin assessment just to reach the completion threshold (while simultaneously attempting not to slow down the transfer to acute care).

For these reasons, **we do not support the proposed increase in data completion threshold from 80% to 90%.** Doing so would solely disadvantage providers who care for complex patients and would not provide any additional incentive for others to report better data.

SNF Value-based Purchasing (VBP) Program

Nursing Staff Turnover Measure. Beginning with the FY 2026 program year (FY 2024 performance year), CMS proposes to adopt this structural measure that uses Payroll-based Journal (PBJ) data to calculate the proportion of employment spells that ended in turnover. Registered nurses (RNs), licensed practical nurses (LPNs) and nurse aides are included in the staff count. The measure is currently used in the Five-Star Quality Rating System but is not included in the SNF QRP.

The AHA does not support this measure for use in the SNF VBP program. We acknowledge the association between higher turnover and lower quality of care. However, performance on this measure would be influenced by market characteristics, state licensing regulations and other factors outside of the facility's control. We question why the measure includes contract nursing staff (or "agency" nurses), who by definition will work at the facility for a short term. SNFs nationwide are facing enormous staffing needs and corresponding shortages. It would be inappropriate to penalize those facilities filling open positions the only way possible. The measure is both overly complicated, with its overlapping windows to assess employment, and overly simplistic, by assigning value to care based on payroll data rather than actual quality of care outcomes. Because of these flaws, the measure is not suitable for use in the SNF VBP program.

Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay). Beginning with the FY 2027 program year (FY 2025 performance year), CMS proposes to adopt this outcome measure that estimates the percentage of residents who have received 101 or more cumulative days of nursing home care by the end of the measure reporting period who experienced one or more falls resulting in bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematomas. A similar measure, Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay), is used in the SNF QRP, but it excludes long-stay residents.

The AHA agrees that the measure addresses a high-priority topic for the SNF VBP program. **However, because the SNF VBP contains no other long-stay measures and this precise measure is not currently included in the SNF QRP, we recommend that CMS adopt the measure for the QRP before considering it for use in the VBP program.** The short-stay version of this measure, which is currently used in the QRP, is topped out, meaning little room for improvement. There are several evidence-based interventions that SNF staff can take to prevent falls, but it is unclear whether these strategies differ for short- and long-stay residents. Similarly, it is not clear whether there is a performance gap between the two patient populations. In order to determine whether this measure gleans useful information about variations in quality of care, CMS can follow the similar protocol that is does for the Hospital VBP program and determine the feasibility and validity of the measure as it is used in the QRP first.

Replacement of 30-Day All Cause Readmission Measure (SNFRM) with Updated Within Stay Potentially Preventable Readmissions (SNF WS PPR) Measure. Beginning with the FY 2028 program year (FY 2025 performance year), CMS proposes to replace the SNFRM with the SNF WS PPR measure. The SNFRM has been used in the SNF VBP program since its inception, but CMS was statutorily required to replace the measure with a measure assessing potentially preventable readmissions rather than all-cause readmissions as soon as practicable.

The original potentially preventable readmissions measure evaluated certain readmissions that occurred 30 days following acute care hospital discharge. However, CMS conducted additional testing and measure development to align the measure's specifications with those defining other potentially preventable readmissions measures. Therefore, the measure that CMS proposes to use in the SNF VBP program beginning with the FY 2028 program year would estimate the risk-standardized rate of unplanned, potentially preventable readmissions that occur at any time during the SNF stay. The index SNF admission must have occurred within 30 days of discharge from a prior proximal hospital stay.

While the AHA supports the replacement of the SNFRM with the SNF WS PPR, we encourage CMS to wait until the measure has undergone the endorsement review process by a CBE. The measure has long been on-deck for use in the SNF VBP program and represents an improvement in usefulness over the measure that is currently used in that program which evaluates all-cause unplanned hospital readmissions. By focusing on potentially preventable readmissions during the SNF stay rather than on a fixed window that might not precisely capture factors influencing readmissions by the SNF, SNFs can use information from this measure to inform their quality improvement strategies and consumers can better assess outcomes of care likely due to facility processes rather than chance.

Health Equity Adjustment (HEA). Beginning with the FY 2027 program year (FY 2025 performance year), CMS proposes to apply an adjustment to the normalized sum of a SNF's measure points on SNF VBP program measures if the SNF serves a relatively high proportion (at least 20%) of residents with dual eligibility status (DES) for Medicaid and Medicare. Based on analysis of measure data from previous years, CMS found that the average performance score for a SNF in the top third of performance that also cares for a high proportion of residents with DES is 8.4 points lower than SNFs in the same tertile of performance who do not care for underserved residents. To close this gap, CMS proposes to implement an adjustment that would add bonus points to a SNF's total performance score (TPS); the number of bonus points would be calculated by a "scaler" rewarding additional points for high performance by the proportion of DES residents served.

The AHA supports CMS' proposed HEA and thanks CMS for recognizing the complex interplay between quality measures and health-related social needs. We share the agency's goal of ensuring that all hospitals are incentivized to deliver high-

quality, equitable care to all patients and communities. CMS has proposed a methodological approach that both acknowledges the factors beyond hospitals' control that may impact their performance in the HVBP, while continuing to encourage high levels of hospital performance. We also appreciate that CMS has proposed the HEA in the form of bonus points rather than adding the HEA to the base TPS. The design of the HEA also ensures that bonus points would be potentially available to all hospitals participating in the HVBP, ensuring that all hospitals share an incentive to deliver higher quality care to patients and communities facing sustained structural challenges. While the AHA believes CMS should continue to explore a full range of approaches to accounting for social drivers of health in quality measurement — including direct risk adjustment where appropriate — we believe the proposed HEA is an important step forward.

We are somewhat concerned about the floor for the underserved multiplier, however. CMS proposes that a SNF's patient population must include at least 20% DES individuals in order to be eligible for an "underserved multiplier" because, by law, the SNF VBP program only pays back 50% to 70% of the payments withheld to fund the program. While the agency proposes a methodology that would result in a higher payback percentage than is currently used (by CMS' calculations, 66% of the withhold would be paid back rather than the 60% the agency currently pays back), **we urge CMS to reevaluate whether it would be possible to lower the floor of proportion of DES patients and pay out the full 70% of the withhold.** In states where Medicaid has not been expanded, those SNFs are likely to serve highly vulnerable populations who would be eligible for Medicaid if located in another state; these SNFs might not be eligible for the withhold while serving populations comparable to facilities elsewhere who are eligible. CMS is allowed by statute to pay out up to 70% of the withhold, and this is an excellent opportunity to use that additional funding to support facilities caring for vulnerable patients.

Due to the disadvantages of using DES as the sole determinant of what constitutes "underserved," we encourage CMS to continue to consider additional factors it could use in this methodology. In the proposed rule, CMS also asks for feedback on potential future changes, such as the incorporation of other variables including area deprivation index (ADI) and receiving the Medicare Part D low-income subsidy (LIS). CMS uses both the ADI and LIS in calculating a HEA in the Medicare Shared Savings Program (MSSP).

The AHA believes both ADI and LIS have merit as variables in the HEA's underserved multiplier and encourages CMS to consider incorporating them. Conceptually, the underserved multiplier is designed to use one or more "proxies" to reflect the extent to which hospitals are caring for underserved populations. No single proxy is perfect, and each carries potential strengths and drawbacks. For example, DES has the significant benefit of being consistently recorded in Medicare administrative data and is relatively easy to tie back to individual hospitals. There also is a body of research showing the link between DES and other measures of social drivers, such as income. At the same time,

DES tends to reflect those patients who face the most significant social needs. Furthermore, Medicaid eligibility criteria can vary across states, which means it may be a more comprehensive reflection of underserved populations for some hospitals than for others.

Similarly, the main strength of the ADI is that it is attempts to create a multi-dimensional picture of the social drivers of health in a community. It draws on multiple data sources—including Medicare administrative data and Census data — and uses 17 indicators of social risk to develop a single score for a geographic region. At the same time, because ADI is calculated at a census-block level, it has the potential to obscure differences within a particular census block. For example, the ADI for a community could look average, but parts of the community may face enormous structural barriers to accessing health care and other supportive resources that lead to better outcomes.

We recognize that combining more than one proxy for underserved status — as CMS does in the MSSP program — also adds potential administrative complexity. However, we believe this concern is outweighed by the potential to draw in multiple sources of information on the patients and communities that hospitals serve and create multiple ways to recognize the structural challenges that patients and hospitals may face in achieving better outcomes.

***

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/

Stacey Hughes
Executive Vice President
Government Relations & Public Policy