



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

June 7, 2021

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
Herbert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

***SUBJECT: CMS-1746-P, 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 2022, Federal Register (Vol. 86, No. 71), April 15, 2021***

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including approximately 100 hospital-based skilled-nursing facilities (SNFs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) SNF prospective payment system (PPS) proposed rule for federal fiscal year (FFY) 2022.

CHA appreciates the thoughtful analysis CMS presents in the proposed rule on a wide range of issues related to the SNF PPS. We respectfully offer comments related to the following issues:

- *SNF Market Basket Update – Forecast Error Adjustment*: Conceptually, CHA supports the continuation of forecast error adjustments to the market basket update when they are appropriate. However, we are opposed to the current adjustment, as CMS has not provided sufficient transparency to understand why the actual 2020 market basket update deviated significantly from the estimate.
- *Recalibrating the Patient Driven Payment Model (PDPM) Parity Adjustment*: CHA appreciates that CMS has not proposed a specific parity adjustment in the 2022 SNF PPS proposed rule. CHA asks that CMS complete a full analysis of changes in 2020 SNF resident case mix as a result of the COVID-19 pandemic before asserting the need for a PDPM parity adjustment. CHA does not believe the analysis presented in the proposed rule fully accounts for the impact of the COVID-19 public health emergency (PHE) on the changes in program spending CMS attributes to the transition from RUG-IV to the PDPM.
- *SNF Value-Based Purchasing Program*: CHA supports the suppression of the SNF Readmissions Measure as proposed. Given that the PHE makes it impossible for CMS to use 2020 SNF Readmissions Measure data to rank SNF performance and calculate a value-based incentive payment as required by statute, CHA asks CMS to use the authority it asserts at code of federal regulations (CFR) [413.338\(d\)\(4\)\(iv\)](#) to grant all SNFs an exemption from the adjusted federal per diem reduction at §1888(h)(6) of the Social Security Act.
- *SNF Quality Reporting Program – New and Updated Measures for 2023*: CHA urges CMS not to adopt its proposed measures for FFY 2023. We urge the agency to develop a measure that

provides more timely and actionable information on health care associated infections (HAIs) in SNFs and provide support to SNFs to improve infection control practices. We also urge CMS to delay adoption of a measure that assesses the rates of health care personnel (HCP) COVID-19 vaccination rates.

Below, please find CHA's detailed comments on each of these important issues.

#### **SNF MARKET BASKET UPDATE – FORECAST ERROR ADJUSTMENT**

CMS proposes to adjust the SNF market basket update downward to account for a forecast error correction of 0.8 percentage points. This stems from the FFY 2020 market basket update (the most recently available FFY for which there is final data). The forecasted or estimated increase in the SNF market basket index was 2.8%, and the actual increase for FY 2020 is 2%, resulting in the actual increase being 0.8% lower than the estimated increase. CMS' current policy requires that it implement a forecast error adjustment if the difference between the estimated and actual amount of change in the market basket index exceeds a 0.5% threshold.

CHA generally supports the use of forecast error adjustments where appropriate and when there is a clear understanding of what is driving the variation between the actual and estimated rate of change. However, in the proposed rule CMS does not provide transparency into what's driving the variance between the estimated and actual 2020 market basket update.

Labor expenses make up a large portion of the market basket — over 70% in 2020 (84 FR 38738). For the actual market basket update to be dramatically lower than estimated in the 2020 final rule implies that labor cost growth was significantly lower in 2020 than was projected. **CHA's hospital-based SNFs report that they have actually experienced higher per-resident labor costs as a result of the COVID-19 pandemic.** This is particularly true for CHA's members, as hospital-based SNFs typically have higher skilled staffing mixes.

This has been driven by a number of trends. First, as has been well documented during the pandemic, there has been a high demand for nurses, which exerted upward pressure on labor costs. Second, SNFs needed to increase staffing to provide care to a sicker population of residents. Finally, working in a direct patient care role greatly increased the risk of COVID-19 exposure, requiring SNFs to provide increased pay to compensate caregivers for the increased risk. **As an example of the impact these trends have had on SNF labor costs, one of our members reports that labor costs per patient increased by 11% due to wage increases and increasing staffing to ensure that optimal resident care was provided.**

We ask that CMS refrain from implementing the forecast error adjustment to the 2022 SNF market basket update. Even if CMS is able to provide transparency into what is driving the variance between the 2020 estimated and actual adjustment in the final rule, SNFs will not have an opportunity to comment on the data used to explain the variance. **CHA believes this is particularly important in light of the increased expenses and resulting losses incurred by SNFs during the COVID-19 PHE.**

#### **RECALIBRATING THE PDPM PARITY ADJUSTMENT**

CMS requests feedback on how to best implement an estimated negative 5% parity adjustment associated with the FFY 2020 transition from the RUG-IV model to the PDPM. **CHA appreciates that CMS has not proposed to implement a PDPM parity adjustment for FFY 2022. We believe this approach is**

**appropriate given the potential issues related to comparability of resident case-mix as discussed in detail below and the time required for additional analysis.**

Given the differences in the PDPM and RUG-IV models, CMS used the percentage of stays in each RUG-IV group in FFY 2019 and multiplied these percentages by the total number of FFY 2020 days of service. It then multiplied the number of days for each RUG-IV group by the RUG-IV per diem rate from 2019 updated to 2020. As part of the PDPM implementation, CMS made significant changes to the SNF patient assessment schedule. **CHA agrees with CMS that it would be inappropriate to attempt to reclassify the data set associated with the 2020 SNF patient population using the RUG-IV model, given the significant differences between the two and the changes implemented to the patient assessment schedule.**

To account for the impact of the COVID-19 pandemic on SNF cases, CMS removed patients with a COVID-19 diagnosis, any patient admitted to the SNF using the three-day stay waiver, and a waiver that allowed certain beneficiaries to renew SNF coverage without first having to start a new benefit period. This results in a slight reduction — from 5.3% to 5% — in CMS' estimated parity adjustment. **CHA strongly supports removing these patients from the analysis, as they were not present in the 2019 data set and clearly skew the results.** While we support removing these cases, we do not believe this limited adjustment to the dataset to remove cases specifically related to COVID-19 or waivers resulting from the PHE fully accounts for the impact of the COVID-19 pandemic on SNF case mixes in 2020.

First, in the early months of the pandemic, there was a well-documented shortage of COVID-19 testing capacity. CHA's members with provider-based SNFs report that they had higher than average caseloads of patients with upper respiratory infections, but some were unable to confirm and report a diagnosis of COVID-19 due to a lack of testing. These patients were sicker than average, which may account for the increase in the nursing and non-therapy ancillary (NTA) components that CMS is attributing to the transition from the RUGS-IV model to PDPM. **Therefore, before CMS confirms the need for a PDPM parity adjustment, CHA asks the agency to analyze the 2020 data and determine if there is a higher-than-expected burden of non-COVID-19 upper respiratory infection cases in the resident case mix. If this is verified, CMS must remove the impact of this increase in sicker patients from the PDPM parity adjustment analysis.**

Second, the COVID-19 pandemic potentially significantly impacted the SNF resident case mix due to moratoriums on non-emergent procedures at hospitals and patient reluctance to seek care. It is possible that the resident population in 2020 skews toward sicker, more medically intense cases as a result of the PHE. Despite this potential, the analysis presented to justify the need for a parity adjustment does not attempt to adjust for changes in resident mix beyond whether a resident in 2020 had COVID-19 or their stay utilized one of the waivers CMS granted as a result of the PHE.

However, subsequent comments by CMS in the proposed rule's discussion of changes to the SNF Value-Based Purchasing (VBP) Program leads CHA to believe that the 2020 SNF population did skew toward sicker, more medically complex residents. Specifically, CMS notes that the "data demonstrated important changes in SNF case mix during the PHE including an 18% increase in dual eligible residents..." Dual eligible residents tend to be sicker than those who are not eligible for Medicaid. We believe this shift toward sicker patients may account for much of the increase in the 2020 actual average case mix index (CMI) CMS observes for the speech language pathology (SLP), nursing, and NTA components

compared to what it expected for these components in its 2019 parity adjustment analysis. These components are driving the need for the parity adjustment.

CHA asks that, before finalizing any PDPM parity adjustment, CMS complete a comprehensive analysis comparing the 2020 and 2019 SNF Medicare resident populations. The results should be made publicly available for comment before CMS implements any parity adjustment. At a minimum, we believe this analysis should examine changes in the percentage of dual eligible residents and the average hierarchical condition category score associated with SNF residents from each year. **If in fact this analysis concludes that SNF residents in 2020 were sicker than in 2019, CHA believes that CMS must adjust the 2019 data it uses to calculate the PDPM parity adjustment to reflect this fact. These patients would require more nursing and non-therapy ancillary services. The increase in payments CMS observes would occur not as a result of changes to the payment model (as CMS asserts) but due to material changes in the resident population's burden of illness.** Otherwise, if CMS fails to complete this comprehensive analysis and make any necessary adjustments to its modeling, it risks overestimating the amount of the PDPM parity adjustment (if it's even necessary) and further harming SNFs that have been financially challenged by the COVID-19 pandemic.

**CHA does not believe it would be appropriate to implement a parity adjustment until the analysis described above is completed. Further, if a payment reduction is necessary, CHA asks that it be phased in over time.** The duration of a phased implementation would ultimately depend on the size of any necessary adjustment. However, we do not believe that the reduction should exceed 0.5% per year. Therefore, as an example, if 2% is the correct adjustment amount, it should be implemented over four years.

#### **SNF VALUE-BASED PURCHASING PROGRAM**

For the FFY 2022 SNF VBP Program, CMS proposes to adopt a policy for the duration of the COVID-19 PHE permitting suppression of SNF readmissions measure data for scoring and payment adjustments in a VBP program year, to avoid holding facilities accountable for distorted or skewed measure results.

CMS proposes to calculate SNF readmissions rates as usual. However, as a result of its measure suppression policy, CMS will not transform the SNF readmission rates into facility performance scores to rank SNFs and calculate value-based payment incentives. Ranking SNFs and using that ranking to calculate value-based performance incentives is required under §1888(h)(4) and §1888(h)(5) of the Social Security Act. Under the proposed rule, CMS would instead assign a performance score of zero to all SNFs. **CHA strongly supports this policy and agrees with CMS' analysis of the data that COVID-19 has distorted the 2020 SNF Readmissions Measure results. As such, we support CMS' proposal to not use the calculated performance scores — based on a readmissions measure suffering from clearly flawed data — to rank SNF performance and calculate the value-based incentive payment.**

However, CMS still proposes to reduce each SNF's adjusted federal per diem rate by 2%. Rather than returning an amount based on each SNF's performance score, CMS proposes to return 60%<sup>1</sup> of the withheld federal per diem as a "value-based incentive payment" to all SNFs. **CHA strongly disagrees with this proposal, as it violates Congress' intent when it established the SNF VBP and the plain language of the Social Security Act.**

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<sup>1</sup> Per policy, 100% of the amounts withheld would be returned to low-volume SNFs.

First, this proposal violates Congress' intent to when it created a SNF VBP Program. The payment reduction under §1888(h)(6) of the Social Security Act is intended to fund value-based incentive payments. The title of the subsection – “Funding for value-based incentive payments” – clearly signals this. **What CMS is proposing, as discussed below, is not a value-based payment in concept nor as described by the plain language of the statute.** While one could argue a payment reduction is a form of incentive payment, there would need to be some methodology — which is lacking in CMS' current proposal — to differentiate high-performing from low-performing SNFs. Additionally, Congress' choice of the word “funding” implies that some participants should receive a positive payment adjustment as a result of the SNF VBP Program. Otherwise, there is no need to “fund” a payment reduction if Congress only intended to mete out penalties as a result of the SNF VBP Program. This logic is clearly borne out in section §1888(h)(5)(C)(ii)(II)(cc) of the Social Security Act, as discussed in detail below.

Second, the proposal to award all SNFs a score of zero and apply the same performance score doesn't create a value-based incentive payment (or payment reduction in this case) as required by statute. Congress, under §1888(h)(4) of the Social Security Act, requires the Health and Human Services Secretary to rank SNFs based on their performance — and, under §1888(h)(5), to use that ranking to determine the value-based payment percentage. **In the proposed rule, CMS clearly states that, while it calculated a performance score, it did not use that score to rank SNFs and use that ranking to calculate a value-based performance incentive payment.**

Finally, the Social Security Act at §1888(h)(5)(C)(ii)(II)(cc) states:

*in the case of skilled nursing facilities in the lowest 40 percent of the ranking under paragraph (4)(B), the payment rate under subparagraph (A) for services furnished by such facility during such fiscal year shall be less than the payment rate for such services for such fiscal year that would otherwise apply under subsection (e)(4)(G) without application of this subsection*

**Congress clearly intended for only the lowest ranking 40% of SNFs to experience a reduction in their adjusted federal per diem rate.** As a result of CMS' proposed policy — and contrary to the statute — 100% of SNFs will experience a reduction in their adjusted federal per diem.

Due to the unresolvable issues arising from the COVID-19 PHE, CMS describes in the FFY 2022 proposed rule with the 2020 Skilled Nursing Facility Readmissions Measure data, the agency clearly cannot use it to calculate the SNF VBP Program incentive payment. As described above, Congress clearly only intended for CMS to reduce the SNF adjusted federal per diem by 2% if it was going to use those funds to make a value-based incentive payment as calculated according to the statute. This includes limiting SNFs that receive a negative adjusted federal per diem to those in the lowest 40% of the SNF VBP Program performance ranking. CMS at CFR [413.338\(d\)\(4\)\(iv\)](#) asserts that it “... may grant exceptions to SNFs (from the SNF VBP Program<sup>2</sup>) without a request if it determines that an extraordinary circumstance affects an entire region or locale.” CHA notes that the singular use of region or locale does not preclude the plural in regulatory construction. **Given that the PHE makes it impossible for CMS to use 2020 SNF Readmissions Measure data to rank SNF performance and calculate a value-based incentive payment as required by statute, CHA asks CMS to use the authority it asserts at CFR [413.338\(d\)\(4\)\(iv\)](#) to grant all SNFs an exemption from the adjusted federal per diem reduction at §1888(h)(6) of the Social Security Act.**

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<sup>2</sup> Added for context

If CMS persists, contrary to Congress' intent and the plain language of the statute, in reducing the SNF adjusted federal per diem, CHA asks that CMS return 70% (instead of 60% as proposed) of the payment reduction to SNFs, as allowed at §1888(h)(5)(C)(ii)(III).

### **SNF QUALITY REPORTING PROGRAM (QRP) — NEW AND UPDATED MEASURES FOR 2023**

CMS proposes several changes for the SNF QRP, including the addition of two new measures for FFY 2023, a modification to an existing measure denominator, and changes to the quarters of data publicly reported to account for the impact of the COVID-19 PHE. CHA is supportive of the proposed change to the Transfer of Health Information to the Patient-Post-Acute (TOH-Patient-PAC) measure and changes to the quarters of data publicly reported. However, we offer the following comments on the newly proposed measures.

#### *SNF Health Care-Associated Infections Requiring Hospitalization*

Beginning with FFY 2023, CMS proposes to adopt a claims-based outcome measure that is intended to address the wide variation reported in HAI rates among SNF providers and to identify infections serious enough to result in acute care hospital admissions. **While CHA agrees that preventing infections is a top priority for SNFs, we are concerned that this measure as specified will not produce timely, accurate, or actionable information for SNFs to improve their infection control practices, and we urge CMS not to adopt the proposed measure.**

Specifically, a claims-based measure is not appropriate for measuring health outcomes such as infections. In other Medicare quality reporting programs, HAIs are reported via the National Healthcare Safety Network (NHSN) using chart-abstracted surveillance data. These data are based on specific clinical indicators gathered using detailed instructions about what cases to include (or not) in the denominator, as well as clinical definitions that only an infection prevention expert can interpret. This scientific process ensures data integrity and provides analytic tools that enable each facility to assess progress and identify where additional efforts are needed. This approach ensures that providers know which patients are infected and can take action to improve infection control practices to protect other patients and staff from infection, unlike a claims-based measure which necessitates a multi-year lag between when the claims are submitted and when the data are used to inform measure performance. Patients and providers cannot afford to wait two to three years to have claims-based data inform HAI reduction efforts.

CHA is also concerned that the measure is not constructed to detect all HAIs, but just those that result in hospitalization and can be identified in the claims. To be included, a SNF patient must go from the SNF to an acute care hospital, and the hospital must submit a Medicare claim indicating both that the HAI was the principal admitting diagnosis and the patient had the HAI at the time of admission. This measure construction is likely to miss some patients who were hospitalized with an underlying HAI, and it ignores HAIs that did not result in hospitalization but should still have been preventable. Successful HAI reduction efforts depend on the rapid and timely identification of infections so that their underlying causes can be addressed before they result in morbidity or mortality.

CHA strongly agrees that SNFs should be held accountable for preventing HAIs. However, we believe this particular measure misses the mark, and we urge CMS to work with stakeholders to develop a measure that can better provide SNFs with timely and actionable information to assist in quality improvement. In the meantime, we urge the agency to work closely with SNFs and deploy quality improvement support to train SNFs on best practices on reducing HAIs.

*Proposed COVID-19 Vaccination Coverage Among Health Care Personnel Measure*

CMS proposes to add a new process measure to the SNF QRP beginning with FFY 2023 to track the percentage of health care personnel who receive a complete COVID-19 vaccination course. CMS proposes an initial data submission period of October 1 through December 31, 2021, for use in the FFY 2023 SNF QRP program, with data reported for at least one week of every month in the reporting period using the Centers for Disease Control and Prevention (CDC) NHSN web-based surveillance system. For FFY 2024 and subsequent years, CMS proposes a full calendar year reporting period. CMS proposes to publicly report the CDC's quarterly summary of the COVID-19 health care personnel vaccination measure.

California's hospitals strongly support the nation's COVID-19 vaccination efforts and have been leaders in vaccinating their communities. **Hospitals remain committed to achieving high levels of vaccination among their employees; however, we are concerned that the adoption of a measure to assess COVID-19 vaccination rates among SNF staff is premature for FFY 2023 with reporting beginning October 1.**

The first COVID-19 vaccine was approved by the Food and Drug Administration (FDA) under emergency use authorization (EUA) on December 11, 2020. EUAs have subsequently been issued for two additional COVID-19 vaccines, and the early evidence has been promising both in terms of vaccine safety and efficacy. Despite increasing levels of COVID-19 vaccination, a degree of vaccine hesitancy remains among the general population, as well as hospital staff. Given the recent availability of vaccines (barely six months), misinformation, and because the vaccines are currently authorized for emergency use — rather than FDA-approved — many facilities have encouraged vaccination among their staff but have not established vaccination as a condition of employment and do not control the vaccination status of their employees. As accurate information about the vaccines dispels myths and vaccines receive full FDA approval (as opposed to EUA), we are hopeful more health care personnel will become vaccinated.

The measure will also increase data collection and reporting burdens on SNFs that do not provide COVID-19 vaccinations directly to their employees and staff. While CMS says that it has modeled this measure after previously required measures to assess influenza vaccination rates among health care personnel, there are key differences between COVID-19 and flu vaccination administration and data collection among staff. Whereas it is common, and in fact states like California require, that health care facilities provide influenza vaccination for their employees on an annual basis, COVID-19 vaccination administration has been much more fragmented. Californians receive vaccinations through providers that have been selected by the state's third-party administrator (TPA) as part of the state's vaccination network, or through pharmacies participating in the Federal Pharmacy Partnership (FPP). Although the FPP provided for the broad distribution of vaccinations to many SNF residents in the early months of 2021, it did not routinely provide direct access to SNF staff. Moreover, many SNFs do not have access to the vaccine on an ongoing basis and do not routinely provide vaccines directly to staff members. Although some general acute care hospitals have participated — and thus may be able to provide access for employees of a limited number of distinct-part SNFs — SNFs have not been part of the state's TPA network in California.

Though early COVID-19 vaccination efforts prioritized certain health care personnel — some of whom were vaccinated within their facilities or health systems — the measure includes a very broad definition of health care personnel that would include many employees, independent contractors, and volunteers who would have been vaccinated in the community. **This measure will place additional burden on SNFs**



**to seek and verify complete vaccination status from their employees whose vaccine may have been provided in settings outside the facility, such as a local pharmacy or county mass vaccination clinic. SNFs will need to devote significant resources to developing systems to track employee vaccination, including which vaccines and how many doses are required for complete vaccination.**

CHA is also concerned that the definition of the measure numerator could be significantly impacted by the potential need for booster shots. Currently, the numerator would assess the cumulative number of health care personnel eligible to work in the hospital or facility for at least one day during the reporting period and who received a complete vaccination course against SARS-CoV-2. Unlike the influenza vaccination — which requires an annual course of vaccination — much remains unknown about the long-term efficacy of the existing COVID-19 vaccines, and a requirement for a booster shot could modify the definition of a “complete vaccination course.” **CHA urges CMS to consider delaying adoption of such a measure until more is known about the long-term efficacy, final FDA approval, and vaccination schedule for COVID-19 vaccines.**

In addition, on May 13, CMS published an interim final rule with comment period (IFC) (CMS-3414-IFC) that requires — as a requirement for participation — long-term care (LTC) facilities to electronically report weekly in a standardized format to the NHSN about the COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID-19 vaccine received, COVID-19 vaccination adverse events, and administration of therapeutics. In its guidance to state survey agencies (QSO-21-19-NH), CMS provides a different definition of “staff” for COVID-19 vaccination reporting purposes than the definition provided for health care personnel under the proposed quality measure. This will cause confusion for hospital-based SNFs subject to both the quality reporting requirements and LTC conditions of certification, resulting in duplicative reporting and additional burden. We urge CMS to reconsider the adoption of a duplicative reporting requirement for LTC facilities.

**CHA is also concerned that the vaccination rates for this measure could vary significantly from the time of data submission to public reporting.** CMS proposes to begin public reporting of the measure on *Care Compare* in October 2022 for the data submitted during the fourth quarter of 2021. We are concerned that the significant lag time between data submission and reporting will not provide patients with accurate data on the vaccination status of health care personnel in a specific facility. In addition, should a booster shot be required for any of the currently available vaccines, the definition of a fully vaccinated individual could change between the data submission and public reporting of the data, providing an even more incomplete window into health care personnel vaccination rates.

Finally, the measure proposed by CMS has not been fully specified, tested, or endorsed by the National Quality Forum (NQF). While CHA understands the immediate challenges posed by the COVID-19 pandemic and the benefits of understanding health care personnel vaccination rates, we do not support the inclusion of measures that have not been thoroughly tested and are not endorsed by the NQF in the Medicare QRPs. **We urge the agency to fully develop and test the measure for reliability and validity — and seek NQF endorsement — prior to adopting it as a required measure in the SNF QRP. CHA urges CMS not to adopt a COVID-19 health care personnel vaccination measure beginning with FFY 2023.**

#### **RFI – CLOSING THE HEALTH CARE EQUITY GAP IN POST-ACUTE CARE QRPs**

California hospitals are committed to improving health equity and eliminating disparities in health care outcomes. Unequal access to health care and health resources due to race, socioeconomic status, and



other social determinants of health has long been of concern to our members — and the COVID-19 pandemic has further demonstrated racial and ethnic health disparities that can no longer be ignored. The reasons for health equity disparity are multi-faceted, and answers to the problem are just as complex. Overcoming these obstacles will require a long-term, systemic approach with collaboration across all levels of government and institutions.

**CHA applauds the administration for its strong commitment to addressing health equity as evidenced by several of President Biden’s executive orders.** We appreciate that, as an early step, CMS is seeking comments on how it can leverage Medicare QRPs to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable for facilities, providers, and patients. Hospitals are uniquely positioned to help advance health equity and reduce disparities, and many of our members have already invested in efforts to improve data collection on race, ethnicity, language preference, and other sociodemographic data. As the agency considers its future steps, we offer the following high-level principles on improving demographic data collection, stratification of quality measure results, and future measures to assess health equity.

#### *Improving Demographic Data Collection*

The collection of standardized, comprehensive, and accurate data is essential to assessing disparities in our health care system. Hospitals have invested significant resources in collecting these data from their patients, but the data are not always captured in a consistent manner and format. For example, it is common for race and ethnicity information to be collected at registration, but other social demographic factors — such as access to transportation or food insecurity — may be captured as part of discharge planning or case management services. The data may also be maintained across separate systems and departments. **CMS should engage stakeholders to understand the current practices for demographic data collection and provide education to promote best practices that ensure consistency in these efforts.**

CHA also urges CMS to assess current efforts to collect demographic data beyond race and ethnicity, such as the standardized patient assessment data elements (SPADEs) required for post-acute care (PAC) settings and International Classification of Diseases, Tenth Revision (ICD-10) z-codes. CHA notes that, while CMS expanded the SPADEs to include a new category for social determinants of health, data collection has been delayed due to the COVID-19 PHE. **CMS should implement and learn from the experience of PAC providers collecting the existing SPADEs before expanding to other settings or adding new data elements. We also urge CMS to engage stakeholders to understand how z-codes are currently used and consider how to better standardize and incentivize this coding.**

#### *Stratification of Quality Measure Results*

CMS says that it is considering providing facilities with reports that would stratify quality measure results by race and ethnicity, similar to its current approach to provide hospitals with confidential hospital-specific reports for several condition- and procedure-specific readmissions measure strategies for dual-eligibility status in the Hospital Readmissions Reduction Program. **CHA supports providing hospitals with confidential hospital-specific reports stratified by race and ethnicity in order to provide hospitals with information that could expose significant disparities. However, we believe that understanding the underlying causes of disparities — such as housing instability, access to healthy foods, and community violence — requires a more granular level of data collection. While dual eligibility status and race or ethnicity have been shown to be accurate proxies for social risk, those characteristics intersect with other systemic factors that result in inequities in our health care system.**

We encourage CMS to continue to explore how it could provide hospitals with actionable data that allow them to work with community partners in advancing health equity in their communities.

*Future Measures to Assess Health Equity*

In the inpatient prospective payment system and inpatient psychiatric facility PPS proposed rule requests for information, CMS discusses the possible creation of a Hospital and Facility Equity Score that would synthesize results across multiple social risk factors and disparity measures. **CHA is concerned that a measure requiring a complex aggregation methodology is unlikely to produce results that are actionable to the facility for quality improvement purposes.** We urge CMS to rethink the development of an aggregate Hospital or Facility Equity Score and instead focus its resources on improving and standardizing data collection and reporting of social demographic data in such a way that provides facilities with accurate and specific data on disparities within and across their facilities.

CHA appreciates the opportunity to comment on the FFY 2022 SNF PPS proposed rule. If you have any questions, please do not hesitate to contact me at [cmulvany@calhospital.org](mailto:cmulvany@calhospital.org) or (202) 270-2143; or my colleague Pat Blaisdell, vice president, continuum of care, at [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org) or (916) 552-7553.

Sincerely,

/s/

Chad Mulvany

Vice President, Federal Policy