



June 6, 2021

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1746-P  
P.O. Box 8016  
Baltimore, Maryland 21244-8016

Dear Administrator Brooks-LaSure:

LeadingAge appreciates the opportunity to comment on 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.

We represent more than 5,000 aging-focused organizations that touch millions of lives every day. Alongside our members and 38 state partners, we address critical issues by blending applied research, advocacy, education, and community-building. We bring together the most inventive minds in our field to support older adults as they age wherever they call home. We make America a better place to grow old. For more information: [www.leadingage.org](http://www.leadingage.org)

Our comments follow below, outlined by section.

#### PROPOSED SNF PPS RATE SETTING METHODOLOGY AND FY 2022 UPDATE

**SNF Market Basket Update.** LeadingAge notes the proposed market basket update for FY 2022 of 1.3% after forecast error adjustment and multifactor productivity adjustment is the slimmest in recent years. LeadingAge's mission-driven nursing home providers already operated on slim margins prior to the COVID-19 pandemic. We note that the unexpected and unprecedented public health emergency has had a significant negative impact on our field through the debilitating combination of decreased revenue due to declining census and increased expenses including personal protective equipment, COVID-19 testing, cleaning and disinfection supplies, and expenses related to effective cohorting that were necessary to protect the safety and well-being of the residents living in our communities and the staff serving them. We urge CMS to consider these extraordinary circumstances, and the importance of financial viability in providing quality care and make adjustments to payment rates.

#### OTHER SNF PPS ISSUES

**Recalibrating the Patient-Driven Payment Model Parity Adjustment.** In evaluating implementation of the patient-driven payment model (PDPM), CMS has discovered an unexpected increase in SNF payments of approximately 5%. To address this increase and return PDPM to its intended budget neutral model, CMS has proposed a parity adjustment that, in part, attempts to remove the influence of the COVID-19 public health emergency. That is, CMS has proposed calculating FY 2020 claims under RUG-IV case mix while eliminating any claims for residents who fall into either of 2 categories: residents who were admitted to SNF care utilizing the Qualifying Hospital Stay (QHS) waiver, and residents who had a COVID-19 diagnosis. In this way, CMS theorizes, they will account for the anomalies in care caused by the COVID-19 public health emergency.

LeadingAge opposes this parity adjustment and associated recalibration methodology. The Patient-Driven Payment Model was a radical overhaul of the SNF payment system, implemented only months before the COVID-19 public health emergency caused significant disruption and pervasive changes to the healthcare system. These changes were unexpected and their impact do not follow the clean lines of COVID-19 diagnoses and QHS waivers. Every nursing home, every nursing home resident, has been impacted by COVID-19 in some way. Simply separating out residents and services rendered based on a diagnosis or billing code will not mitigate the impact of this pandemic.

While some residents receiving SNF care under the QHS waiver may not have qualified for a 3-day stay under normal circumstances, many residents who utilized the QHS waiver likely would have qualified for a 3-day stay but instead were discharged early due to hospital surge. Still other residents who may have qualified for a 3-day stay utilized the waiver as a measure of safety to prevent further COVID-19 exposure in an acute care setting. Eliminating these residents from parity adjustment calculations would be counter to the logic for eliminating those utilizing the QHS waiver.

One must also consider the resulting impacts of hospital surge on case mix. Hospitals were discharging people earlier to allow for surge capacity, so residents were coming to the SNF in a more acute state than they would have without the PHE. While some of these individuals may have discharged before 3 days and utilized the QHS, others may have stayed longer than 3 days, yet still discharged earlier than conventional standards of care would have recommended. These individuals would not be eliminated from parity adjustment calculations, but nonetheless reflect unexpected changes in care as a result of the PHE.

Additionally, one should consider the impact of pandemic operations. Visitation was restricted for 6 months. Group activities and communal dining were modified in significant ways and still have not stably recovered to pre-PHE operations. We knew before the PHE how social isolation could impact things like mood, cognitive functioning, and physical functioning, which in turn directly impact case mix indices. The PHE and resulting changes to nursing home operations triggered declines in these areas of functioning for many residents beyond the subset of those diagnosed with COVID-19 or those who utilized a QHS waiver.

Lastly, we know how unprepared our nation and health system were for this PHE. We know that the virus likely circulated for months undetected, and we may have provided SNF care to individuals who were struggling to recover from COVID-19 and its after-effects without proper diagnosis and coding. We also know that nursing homes had limited ability to physically provide for surge capacity. Waivers were implemented to allow for temporary construction and alternative care sites, yet in many cases, nursing homes had to resort to cohorting COVID-positive residents. Without adjustments to the coding system, nursing homes could not properly code for the isolation care being provided.

For all of these reasons, one cannot assume that simply separating residents with COVID-19 diagnoses or 1135 waiver billing codes on their claims from aggregate SNF claims will provide accurate data on which to calculate parity adjustment, nor can one assume that excluding claims during a certain time period will provide accurate data. LeadingAge opposes a PDPM parity adjustment at this time. Due to the profound and pervasive impact of the COVID-19 public health emergency, CMS must collect more data before making any adjustments to the payment model. We recommend evaluating at least 12 months of data beginning with the first full month after the expiration of the public health emergency before determining parity adjustment.

## SKILLED NURSING FACILITY (SNF) QUALITY REPORTING PROGRAM (QRP)

### **Proposed Skilled Nursing Facility (SNF) Healthcare-Associated Infections (HAI) Requiring**

**Hospitalization Quality Measure Beginning with the FY 2023 SNF QRP.** We understand the importance of avoiding unnecessary healthcare acquired infections (HAI) and that many of these are preventable. We appreciate that CMS will not implement this as a QRP measure until such time as it receives NQF endorsement and that once the measure is to be implemented, CMS will calculate the measure using claims-based data so as not to add additional reporting burden on providers. However, we are concerned that FY 2021 will include COVID-19 data and therefore will be incomparable to FY 2019 non-COVID data. We recommend delaying the adoption of this measure until data can be collected outside of the public health emergency.

Additionally, recognizing that one goal of the SNF QRP program is to improve quality in SNFs, we have a number of recommendations to support this goal. First, there needs to be transparency and clarity around the data and measure calculations. If providers are able to conduct their own calculations, they can make changes to the infection control and quality improvement programs in real time.

When calculating the measure, CMS should be clear about the specific formula and data used to calculate the estimated number of SNF stays expected to have an HAI. We found with the SNF Nursing Home Infection Control Incentive Program under the Provider Relief Fund program that it was difficult for SNFs to understand their performance scores in comparison to the county-level infection rate because the data used for comparison and to achieve an equivalent infection rate were not publicly available, or at least never communicated. So, providers may have had extraordinarily low rates of infection and still were ineligible for incentive payments.

It is also important to provide SNFs with appropriate feedback reports. For this measure, we recommend a patient-level feedback data report to affect changes in performance. The proposed rule does not adopt such a report as part of this requirement to the program. Nonetheless, there should be a process in place for CMS to share the reported data with the nursing homes so that they may review and make corrections prior to publication of the data to Care Compare.

Lastly, we encourage CMS to continue development of best practices, tools, and templates. TEP members believed that the HAI measure would incentivize providers to focus on HAIs but noted that barriers to action may exist, including lack of knowledge, inadequate staff-to-resident ratios, staff turnover, and provider resources. Without a collaborative effort to address these barriers, it would be premature to implement the HAI measure.

**Proposed COVID-19 Vaccination Coverage Among Healthcare Personnel Measure Beginning with the FY 2023 QRP.** CMS proposes to adopt for FY 2023 a process measure on COVID-19 vaccination rates of staff in long-term care. This measure would be based on data reported to the National Healthcare Safety Network, newly required with interim final rule CMS-3414-IFC. While LeadingAge supports vaccination of healthcare personnel, we oppose the addition of this measure to the SNF QRP for FY 2023.

Through our efforts and constant communication with our members, we have learned that while vaccine acceptance is increasing nation-wide, there are still many individuals providing quality care who remain vaccine hesitant. Vaccination is a personal choice impacted by several factors, including a very volatile political climate and mistrust toward the government, and is no indication of the ability or the willingness of an individual to provide quality care to residents living in a nursing home. Adding this measure to the SNF Quality Reporting Program mistakenly conflates the ability of a nursing home to overcome the independent, individual medical choices of its healthcare personnel with the ability of the nursing home to provide quality care to the residents living within.

We note that CMS has stated in the rule that publishing COVID-19 vaccination rates on Care Compare (as a QRP measure) would be helpful for consumers as they choose where to seek post-acute care. While we agree that COVID-19 vaccination rates could be useful for this purpose, one must consider that COVID-19 vaccination rates for both staff and residents are now posted on the nursing home site at [data.cms.gov](https://data.cms.gov) as a result of the new reporting requirements in interim final rule CMS-3414-IFC. Adding a COVID-19 vaccination measure to the QRP for the stated purpose of transparency is not only duplicative and unnecessary, but could also be more confusing.

While the nursing home data site is updated weekly, Care Compare is updated only monthly. Further, the data used for quality measures is based on reporting periods. As proposed, consumers viewing the COVID-19 vaccination QRP measure would be viewing average vaccination rates from the prior quarter, rather than the vaccination rates of residents and staff currently living and working in the nursing home. This outdated data defeats the purpose as proposed by CMS.

Further, we are concerned about the possibility of a double penalty that arises from the interplay of a QRP measure on COVID-19 vaccination and the requirements of interim final rule CMS-3414-IFC. Under the interim final rule, a nursing home is cited at F884 Reporting – NHSN and automatically enforced a \$1,000 civil monetary penalty (CMP) for failure to report COVID-19 vaccination data for a given week. This CMP is applied for each episode of noncompliance and increases incrementally by \$500 for each subsequent episode of noncompliance.

Under the QRP program, SNFs incur a 2% reduction in their Medicare fee-for-service rates if the SNF fails to report 100% of the required data to calculate a measure at least 80% of the time. While the SNF QRP contains many measures, failure to report one week of vaccination data could trigger the 2% rate reduction for a full calendar year. In effect, this could mean that a SNF would be penalized twice for the same failure to report: once with a CMP for noncompliance at F884 and a second time for incomplete data submission on the QRP measure.

We also have concerns about implementing a measure based on NHSN data given the issues providers have experienced in the past. Providers missed out on critical financial relief from the nursing home infection control payments under the Provider Relief Funds due to reporting errors of which they were unaware. There was no process in place for SNF providers to receive feedback on data submissions and correct any errors before the data was made public and assessed for infection control payments. Given the penalties associated with failure to report data for the SNF QRP, it is critically important that there be a way to identify potential errors in submissions and correct them in advance of the assessment of a penalty. The proposed rule offers no detail about a feedback process or mechanism and we are concerned that without correcting this issue, it will result in penalties to SNFs because reported data is not accepted.

**Proposed Update to the Transfer of Health (TOH) Information to the Patient – Post-Acute Care (PAC) Measure Beginning with the FY 2023 SNF QRP.** LeadingAge supports the proposed update to the denominator for the Transfer of Health (TOH) Information to the Patient to exclude those discharges that go to home health or hospice services to eliminate double counting. However, we believe it is premature to introduce this measure in the FY2023 SNF QRP program year as the assessment data will not be available to calculate performance.

In particular, it is our understanding that the TOH measure revision requires the use of MDS item A2105 – Discharge Status, which was intended to replace existing item A2100 on October 1, 2020. However, due to the COVID-19 PHE and other factors, this item was not introduced. In addition, CMS noted in COVID-19 rulemaking on May 8, 2020 (CMS-5531-IFC) that it would not begin collecting this information

until a particular point in time after the PHE has ended. Specifically, “Therefore, we will require SNFs to begin collecting data on the two TOH Information Measures beginning with discharges on October 1<sup>st</sup> of the year that is at least 2 full fiscal years after the end of the COVID-19 PHE (85FR 27596).”

**SNF QRP Quality Measures Under Consideration for Future Years: Request for Information (RFI).** CMS has proposed 5 future measures and measure concepts for consideration for inclusion in the SNF QRP in future years. LeadingAge appreciates CMS interest in potential future QRP measures related to frailty, patient reported outcomes, shared decision-making process, appropriate pain assessment and management process, and health equity. We are unable to provide that feedback at this time but look forward to engaging in further discussion as CMS is able to be more specific about measures it might be considering. We will engage our members on these potential measure areas and solicit feedback, as the COVID-19 public health emergency begins to wind down.

#### SKILLED NURSING FACILITY VALUE BASED PURCHASING (SNF VBP) PROGRAM

**Proposal to Suppress the SNFRM for the FY 2022 SNF VBP Program Year.** CMS proposes to suppress the Skilled Nursing Facility Readmission Measure for FY2022 in acknowledgement of variation in SNFRM performance during the COVID-19 pandemic. LeadingAge supports this approach and the suppression factor measures to be used. However, we have concerns about how CMS is approaching the payment adjustment required by the program, which would result in a 0.8% reduction for nearly all SNFs in FY2022.

LeadingAge believes that any reduction to SNF rates at this financially precarious time is potentially damaging and unwarranted. However, we recognize in order for CMS to hold all SNFs harmless on the SNF VBP adjustment in FY2022 that it would require a law change. The SNF VBP law requires CMS to annually create an incentive pool by withholding 2% of SNF Medicare FFS rates and only permits it to return 50-70% of these funds. CMS has opted to return just 60% of the funds for FY2022. While this is comparable to prior years, LeadingAge strongly urges CMS to return the maximum amount permissible – 70% -- under law to SNFs in years where the SNFRM is suppressed. This would reduce the cut to SNF rates down to 0.6%.

CMS asks for the flexibility to suppress quality measures during future public health emergencies. While we support the measures that CMS would use for this purpose, we think there should continue to be an opportunity for stakeholders to provide input into other effects of the suppression such as how the value-based payment adjustment under SNF VBP is applied or the reporting of the performance on the suppressed measure on Care Compare or its successor. For these reasons, we think CMS should have to go through the rulemaking process when suppressing measures to ensure the approach is fully vetted.

LeadingAge supports providing SNFs with quarterly confidential feedback reports covering time periods during the public health emergency but does not support publicly reporting the SNFRM rates for FY2022 for the very reasons CMS cites. CMS itself notes that the data is unreliable, “We do not believe that assessing SNFs on a quality measure affected significantly by the varied regional response to the COVID-19 PHE presents a clear picture of the quality of care provided by an individual SNF.” If these data do not accurately reflect quality of care, they should not be reported on Care Compare for consumers to use as representative of quality in a particular SNF. Finally, as noted in the proposed rule, the SNFRM also does not risk adjust for COVID-19 diagnosis and therefore, should not be publicly reported until it does.

**Proposed Revision to the SNFRM Risk Adjustment Look-Back Period for the FY 2023 SNF VBP Program.** Regarding the proposed SNF VBP Performance Period for FY2023 & FY2024, we are concerned that the proposed FY2023 performance period is not being risk-adjusted for those with COVID-19 infected residents, given that it includes third and fourth quarter of 2020 data. As noted above and within the

proposed rule, the data during the PHE are unreliable, the impact of COVID-19 varied regionally, and the SNFRM doesn't risk adjust for COVID-19 making it impossible to compare SNF performance during these timeframes to non-COVID baseline data.

For FY2024, while we understand the need to use a different baseline year, we are concerned that FY2019 data is so old as it is no longer relevant or comparable. We think CMS should implore Congress to pause the application of the SNF VBP incentive payment adjustments and hold providers harmless for performance dates impacted by the PHE.

**Request for Comments on Potential Future Measures for the SNF VBP Program.** Regarding CMS's request for suggested measures to be added to the SNF VBP program, we recommend that CMS begin considering measures through the lens of what determines value for the individuals being served and the outcomes we seek to achieve through the VBP program. LeadingAge thinks CMS should use a framework or criteria for which measures should be included. We propose the following criteria be used for evaluating which quality measures should be adopted as part of the SNF VBP in determining the incentive payments:

- Measures that have been validated and/or approved by NQF for the setting in which they are applied.
- Measures for which providers can substantially impact the outcome or performance
- Measures that affect quality of life for residents

Where possible, measures should be consistent across programs (e.g. at present, there are different rehospitalization definitions and reporting periods for SNFs in VBP, QRP and reported on Care Compare)

- Measures where there is a low administrative burden for data collection (e.g. claims based)
- Measures for which there is statistically significant variation among providers
- Measures should be risk-adjusted including accounting for social risk factors.
- Measures should be appropriate to the population and their health status.

We would note that some of the QRP measures already meet the criteria we laid out above, such as:

- Change in mobility score
- Change in self-care score
- High risk residents with pressure ulcers
- Discharge to community post-acute is a key post-acute rehabilitation measure

Other measures should be validated as reliable and endorsed by NQF before adoption especially if a SNF's performance is tied to financial consequences as it is under the SNF VBP. CMS should also evaluate whether it needs to add a full 9 measures to the SNF VBP to adequately assess the value the SNFs are delivering to those for which they provide care. For example, measures such as the proposed Healthcare Associated Infections Requiring Hospitalization (HAI), which CMS is proposing to add as a SNF QRP measure assess quality of care, which cannot be delivered without adequate staff and training, strong performance on infection control and avoidance of unnecessary rehospitalizations. LeadingAge would recommend CMS takes a phased approach to adding measures to SNF VBP in order to give SNFs time to focus on being successful.

When it comes to staffing measures, we believe the quality of the care received is the best indicator of sufficient staffing levels, low turnover and adequately trained staff. If CMS were to pursue staffing measures, merely collecting data on the number of nursing staff by type doesn't tell the whole story. A SNF could have adequate or above average level of staff but if they are all new on the job, they don't likely know the residents very well yet and may have additional training to complete. In addition, how would such a benchmark be set? While there are minimum staffing expectations, this fluctuates daily by the number of residents receiving care.

Studies show that consistent staffing is important to quality of care. In the past, this has been gauged by how quickly staff respond to call buttons and minimize the development of pressure ulcers. LeadingAge would also argue that this is the wrong time to implement a staffing measure as it would not represent a realistic baseline given the volatility of staffing during the pandemic. Should CMS opt to pursue a staffing measure at a future date we would hope they would choose to use data already reported through the Payroll Based Journal reporting requirements or otherwise available to minimize the reporting burden on SNFs. As noted above other quality of care/outcome measures can be equally effective in determining not only desirable outcomes but also whether the SNF has sufficient staff who are appropriately trained.

LeadingAge would like to raise concerns with using a measure such as Average Medicare Beneficiary Spend. While on the surface, this appears to be a good measure of cost-effective care, the reality is that providers who serve higher needs patients or residents will be disadvantaged as their payment per diem is higher which will, in turn, drive up the average beneficiary spend. For example, the PDP rate might be higher for ventilator patients than someone with a hip fracture, and the number of days of SNF care needed will also vary depending upon co-morbidities and the reason for the SNF care. Therefore, it is not reflective of poor care or care management but more a product of who is being served by the SNF and their individual needs. In addition, we must consider how much of the cost of care the SNF and its staff are able to affect.

We support the idea of a consumer/patient experience measure but would caution that it should be based upon something like CORE Q, which gets to the heart of the issue -- would someone recommend the provider -- in just a few questions. Patient surveys should not have extensive questions as it is likely to reduce participation and as such, provide an incomplete or skewed view of patient perception of care. In addition, CMS should also take into account that, in some cases, the patient's family caregiver is completing the survey and therefore unable to respond to certain questions as they are not the person experiencing the care nor the condition requiring the care. Again, this makes the COREQ questions more universal and able to be answered by either the family caregiver or patient.

As to the question CMS poses about expanding the SNF VBP measures to assess the quality of care for all residents of the facility regardless of payer, LeadingAge would be supportive but with the following caveat -- not all measures should apply to all residents within the nursing home. The goals of short stay residents and long stay residents are different and therefore, certain measures, if selected, should not be applied across all populations within the nursing home.

For example, for short-stay residents, improvements in functional status make sense, as typically a short-stay is for the purposes of rehabilitation following an illness and/or hospitalization and the objective is for the person to return home. However, functional status measures such as, needs assistance with activities of daily living (ADLs) can produce misleading results when an individual needs additional help for a short period of time due to a hospitalization or illness. In addition, decline over time can be expected for a long-stay resident population resulting in an increasing need for help with ADLs.

Traditionally, CMS has designated measures as applying to either the short or long stay populations within the nursing home. Whether a resident is considered short or long stay is determined based upon whether that person has been in the nursing home more or less than 100 days. The flaw with this approach is some individuals who reside in the nursing home for less than 100 days may actually be more newly admitted for custodial care versus rehabilitating from a hospital stay. Therefore, including them in short-stay measures merely muddies the data on performance as the goals of individuals who are admitted post-acute are considerably different than those requiring ongoing, custodial care.

For example, rehabilitation stays must show progressive improvement and have a goal that the person will return to the community. In contrast, for custodial care residents, the nursing home is their place of residence. Their intent is to stay there and receive ongoing care and supports. Therefore, as CMS considers adding new measures for SNF VBP that encompass the entire nursing home population, we would recommend CMS take this opportunity to re-evaluate its definition of the two distinct populations within the nursing home to better reflect the goals, health status and needs of these individuals.

Alternatively, now might be a good time to consider other measures that are more reflective of a patient-centered approach and quality of life for the individual. We admit this requires additional thought and LeadingAge looks forward to working with CMS to identify measures that would be appropriate.

LeadingAge also supports performance data being collected across all payers from the perspective of Medicare Advantage (MA), given that in certain markets around the country, MA enrollees can represent more than 50% of the population. Under the current SNF VBP program, these SNFs are scored based upon fewer eligible stays and in some cases are excluded from the performance calculations altogether. Performance data can be skewed if it doesn't include the entire population served.

In addition, having data on nursing home residents across payers would allow for the assessment of efficacy of Medicare Advantage (MA) plan utilization management and care management activities in comparison to the fee-for-service (FFS) population. Are shorter lengths of stay equally effective? How often do MA enrollees return to the hospital vs. FFS? LeadingAge suggests that if CMS opts to track performance across payers, CMS should also require those payers (e.g., MA plans) to pay a similar value-based incentive payment to SNFs based upon that performance.

Again, LeadingAge appreciates the opportunity to submit comments on the proposed rule. We value our collaborative relationship and look forward to working together toward improved quality of nursing home care. Please do not hesitate to contact us if you wish to discuss any of these comments further.

Sincerely,

A handwritten signature in black ink that reads "Jodi Eyigor". The signature is written in a cursive, flowing style.

Jodi Eyigor  
Director, Nursing Home Quality & Policy