June 9, 2022

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS-1765-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Dear Administrator Brooks-LaSure:

LeadingAge appreciates the opportunity to comment on CMS-1765-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 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels. We value the public comment process that allows stakeholders to have an active role in policy making and reflect the voices of our nursing home members in our comments below.

About LeadingAge: 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

Skilled Nursing Facility Market Basket Update

CMS proposes a 3.9% market basket update to the skilled nursing facility (SNF) prospective payment system (PPS) for fiscal year (FY) 2023. This 3.9% update is the result of a 2.8% market basket percentage with a 1.5% increase based on forecast error, less a 0.4% productivity adjustment. This rate is a reflection of the changing market and responding payment methodology and **LeadingAge supports a 3.9% payment adjustment for the SNF PPS in FY 2023.**

Proposed Permanent Cap on Wage Index Decreases

CMS proposes applying a permanent 5% cap on any decrease to a provider's wage index from its wage index in the prior year, regardless of the circumstances causing the decline. In FY 2023,

a SNF's wage index would not be less than 95 percent of its final wage index for FY 2022, regardless of whether the SNF is part of an updated core based statistical area. In subsequent years, a provider's wage index would not be less than 95 percent of its wage index calculated in the prior FY.

LeadingAge supports a permanent cap on wage index decreases across our member provider settings. However, we recommend the percentage cap should be lower than the proposed 5%, should be applied in a non-budget neutral way, and should be made retroactive for all provider types. Applying the cap in a non-budget neutral way will ensure that when significant economic downturns occur, all providers will be protected from significant reductions. Based on feedback from LeadingAge members, we also found that most wage indices do not swing by 5% and even a 2% wage decrease impacts operations.

Recalibrating the Patient-Driven Payment Model Parity Adjustment

CMS proposes a 4.6% parity adjustment to the patient-driven payment model (PDPM) for FY 2023. When CMS implemented PDPM in FY 2020, the intent was for the new payment model to be budget neutral, resulting in neither an increase nor a decrease in SNF Medicare A payments. CMS reports that implementation of PDPM inadvertently increased SNF payments by nearly 5% and proposed a parity adjustment in FY 2022 to ensure budget neutrality.

Recognizing the impact of the COVID-19 public health emergency (PHE), CMS proposed a methodology in calculating recalibration that excluded SNF residents who fell into one of 2 categories: residents who were diagnosed with COVID-19 and residents who were admitted to the SNF for skilled care utilizing the Qualifying Hospital Stay waiver implemented in 2020.

LeadingAge opposed the parity adjustment in FY 2022, citing that the onset of the PHE only months after PDPM implementation combined with the pervasive impact on the health and well-being of all residents, including those who had not been diagnosed with COVID-19 or utilized the Qualifying Hospital Stay waiver, and nursing home operations prohibited an accurate evaluation of PDPM and therefore, the parity adjustment should be delayed until after the end of the PHE when more stable data could be collected.

In response to these comments, CMS adjusted methodology to utilize a data collection control period that included 6 months of data from FY 2020 (October 2019 – March 2020) and 6 months of data from FY 2021 (April 2021 – September 2021) when data suggests that COVID-19 case prevalence was relatively low. This updated methodology resulted in the parity adjustment from a proposed 5% in FY 2022 to the 4.6% proposed for FY 2023.

LeadingAge opposes PDPM parity adjustment at this time. We recognize that CMS must reconcile the model to achieve the intended budget neutrality. We further recognize that CMS has updated the parity adjustment to account for the ongoing PHE. However, it is for this very reason that LeadingAge cannot support the parity adjustment. Nursing homes continue to struggle financially. Care needs and resource needs have not decreased and as our nation

continues to experience new variants and surges in waves, our nursing homes must adjust staffing and personal protective equipment (PPE) in the care of SNF residents.

CMS states that resident classification and care provision was impacted by the implementation of PDPM. This fact is undeniable and should have been expected. In the months leading up to PDPM implementation, nursing homes across the country attended trainings, including trainings provided by CMS, emphasizing the importance of accurately identifying and treating resident conditions, including conditions such as depression, that were not previously accounted for, and swallowing issues, that were not adequately accounted for under the previous payment system. CMS is likely correct that resident acuity post-PDPM probably differed very little from resident acuity pre-PDPM. Nursing homes simply improved their ability to classify and treat resident acuity.

Six months later, we entered the PHE and acuity increased broadly across the nursing home population, regardless of a resident's COVID status or utilization of the Qualifying Hospital Stay waiver. It defies logic to think COVID impacted only those touched directly. Similarly, it defies logic to think that a payment system should not be responsive to care costs. The cost of medical supplies has increased, as has the cost of staff to provide the care. CMS may defend an implementation plan that did not appropriately anticipate improvements in quality of care, but CMS cannot defend a plan to pay less for care that costs more. Nursing homes are closing all across the country due to present and post-COVID implications. Challenges will be further exacerbated by implementation of the parity adjustment.

Request For Information: Infection Isolation

CMS requests information on coding infection isolation on the Minimum Data Set (MDS). The Staff Time and Resource Intensity Verification (STRIVE) project in 2005 determined that there was a relative increase in resource utilization and costs associated with treating patients with active isolation, including the personal protective equipment (PPE) and additional protocols required for treating that patient, and the payment system was adjusted to account for those costs.

In order for an individual to be coded for infection isolation on the MDS, the individual must meet 4 criteria: 1) the individual has an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2) Precautions are over and above standard precautions. That is, transmission-based precautions must be in effect. 3) The patient is in a room alone because of active infection and cannot have a roommate. 4) The patient must remain in his or her room and all services must be brought to the resident.

Individuals diagnosed with COVID-19 meet these criteria. COVID-19 was and continues to be highly transmissible with pathogens acquired through contact or droplet transmission and, in the case of aerosol-generating procedures, through airborne transmission. Individuals diagnosed with COVID-19 require transmission-based precautions, which include isolation. In

the nursing home, the resident is isolated to his or her room per CDC recommendations and all services must be brought to the resident. Yet, because of overwhelming case rates across the country and quarantine recommendations for new admissions resulting in the need to cohort residents, nursing homes have been able to code infection isolation for only a fraction of the residents who otherwise meet criteria.

CMS asks whether the relative increase in resource utilization for each of the patients within a cohorted room, all with an active infection, is the same or comparable to that of the relative increase in resource utilization associated with a patient that is isolated due to an active infection. Our members report that the increase in resource utilization is the same and **LeadingAge urges CMS to adjust infection isolation coding on the MDS to allow for coding of cohorted individuals** who otherwise meet the criteria of active infection requiring transmission-based precautions and isolation to the resident room.

The cohorting of residents with similar active infection is an arbitrary distinction rendered necessary only because of space constraints. The costs of caring for a resident in a cohorted room is no different than the cost of caring for a resident in a private room. A resident with active infection requires the same care and treatment, regardless of whether he has a roommate on the other side of the curtain. The staff caring for this individual don the same amount and type of PPE, regardless of whether the resident has a roommate. The staff must follow protocols to properly doff and re-don new PPE for each resident for whom they provide care, regardless of whether the residents under their care are in the same room or separate rooms. A resident's care is individualized according to the resident's needs and payment should be reflective of the costs associated with those needs.

Skilled Nursing Facility Quality Reporting Program

LeadingAge supports transparency around the quality of care provided in nursing homes. We recognize that quality measures are an essential tool for providing both consumers and providers with objective data on the care provided. However, we caution CMS against rendering this information meaningless by sheer overwhelm of data. Currently, nursing home care is tracked and reported on Care Compare through 17 short-stay measures, 16 long-stay measures, and additional staffing measures. The Quality Reporting Program reports on 15 measures and the Value-Based Purchasing program currently reports one measure but can be expanded up to 10 measures. LeadingAge encourages CMS to examine the overlap, the differences, and the magnitude of quality measures to which SNFs are subject to identify any opportunities for streamlining information.

Additionally, as CMS begins to add new measures to any of these programs, it will be important for measures to be risk-adjusted to consider the effects of COVID-19. At present, the broader implications on health care utilization of long COVID patients is unknown. For example, will these individuals have more infections, be susceptible to more chronic conditions, and/or be hospitalized or re-hospitalized more frequently? All QRP and VBP measures should risk adjust

for individuals who are currently infected with COVID-19, those who have recently recovered but may have some lingering effects, and those diagnosed with long COVID in order to account for different expected health care utilization patterns and increased resource intensity of services provided to these individuals.

Further, for both the SNF QRP and VBP programs, we remain concerned that the data considered in calculating measures is limited exclusively to Medicare fee-for-service (FFS) data. On a national level, nearly 47% of Medicare eligible beneficiaries are enrolled in a Medicare Advantage (MA) plan or Special Needs Plan (SNP). By limiting calculations to Medicare FFS data, the quality of care delivered for these individuals is excluded from the calculations.

SNFs in areas where MA/SNP penetration exceeds 50-60% or more are held accountable for quality in the QRP and VBP programs and have their rates impacted based on only a small proportion of residents to whom they provide care. In these areas of the country, we get an incomplete picture of the quality delivered by these SNF providers. Due to the lack of MA/SNP data, we also don't know how quality may vary between Medicare FFS and MA/SNP beneficiaries. We encourage CMS not to leave these beneficiaries behind and ensure they, too, are receiving quality care by requiring plans to share their data with CMS.

Skilled Nursing Facility Quality Reporting Program: Influenza Vaccination Coverage among Healthcare Personnel Measure

CMS proposes to adopt the Influenza Vaccination Coverage among Healthcare Personnel measure for the SNF Quality Reporting Program (QRP) beginning FY 2025. This process measure, endorsed by the National Quality Forum, would report on the percentage of healthcare personnel who receive the influenza vaccination during a given season. CMS proposes that SNF providers would report data at least once per season through the National Healthcare Safety Network (NHSN) system, with "season" being defined as October 1 – March 31 of each year.

LeadingAge supports adoption of the Influenza Vaccination Coverage among Healthcare Personnel measure. Influenza vaccination is an important tool in protecting the health and wellbeing of residents in long-term care and the staff caring for them. Reporting this measure promotes safety and increases quality of care in nursing homes. Noting that this measure is already in use in long-term care hospitals and inpatient rehabilitation facilities, adoption of this measure is consistent with the CMS initiative of alignment of measures across CMS programs.

However, LeadingAge urges CMS to be cautious in executing reporting for this measure. As healthcare personnel influenza vaccination data is not currently reported by nursing homes, new processes will need to be implemented. CMS must provide ample notification to providers through varied methods of communication to ensure reporting of this measure. Should CMS choose to enforce a reporting requirement, it is crucial that reporting requirements align with the specifications outlined in this proposed rule. CMS should require reporting of this data only once per season, rather than more frequent reporting as is currently required of COVID-19

vaccination data. We additionally caution CMS that enforcement of any requirement must follow a traditional citation route without automatic financial penalties, recalling that providers who fail to report this information will be penalized through the QRP construct.

Skilled Nursing Facility Quality Reporting Program: Collection of Certain Standardized Patient Assessment Data Elements

CMS proposes collection of certain standardized patient assessment data elements (SPADEs) to begin with FY 2024, or October 1, 2023. While data collection was previously delayed to October 1 that is at least 2 full fiscal years after the end of the federal public health emergency, the revised data collection date of October 1, 2023 is 3 full years after the initial compliance date finalized in the FY 2020 SNF PPS rule.

LeadingAge supports the revised data collection compliance date of October 1, 2023 for certain SPADEs. We recognize the importance of collecting this data to advance health equity and improve quality of care for all beneficiaries. We note that the revised data collection date is further in the future than dates of data collection for SPADEs across long-term care hospital and inpatient rehabilitation facility Quality Reporting Programs and appreciate CMS's acknowledgement of the unique support needs of SNFs during the COVID-19 public health emergency.

CMS states that training and education will be provided to prepare SNFs for implementation and, as the SPADEs are reported on the Minimum Data Set (MDS), a draft of the updated version of the MDS would be released with sufficient lead time to prepare for the October 1, 2023 implementation date. LeadingAge recommends that the draft MDS be made available at least 6 months prior to the October 1, 2023 implementation date to allow providers time to train on the new SPADEs and examine 2 quarters' worth of data prior to inclusion in the SNF QRP.

Skilled Nursing Facility Quality Reporting Program: Request for Information – Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs

CMS requests information on measuring health equity and healthcare quality disparities across quality programs. The rule proposes several overarching principles and approaches for consideration. LeadingAge supports the use of stratified measures to assist providers in identifying disparities in care. In addition to providing confidential feedback to nursing homes on stratified measure results to help identify disparities in care, LeadingAge recommends providing information to make this feedback meaningful to nursing homes, such as how to interpret the information and what can be done to address identified disparities. CMS should also use the cumulative data to identify disparities at a regional or national level on which targeted training and resources could be provided, either by CMS or by the Quality Improvement Organizations (QIOs).

LeadingAge supports selecting and prioritizing quality measures based on the guiding principles proposed to allow for stratified measure results for disparity reporting. These guiding principles include using existing clinical quality measures that have met industry standards for reliability and validity, prioritizing measures where evidence has shown outcome is affected by underlying healthcare disparity, establishing statistical reliability and representation prior to reporting results, and prioritizing reporting of measures that show differences in performance between subgroups across providers to ensure that reported results are meaningful. We recommend that when reporting these measures, CMS include information to make these measures meaningful and useful to providers.

LeadingAge supports the use of area-based indicators of social risk to identify and stratify social risk factors. A self-report demographic like the social determinants of health reported through the standardized patient assessment data elements gives a picture of the unique resident's perspective, while the area-based indices provide objective data on the risk factors present in the resident's usual environment. While varied data will be important in identifying social risk factors, more information would be needed to support the use of imputed data sources.

Skilled Nursing Facility Quality Reporting Program: Request for Information – Inclusion of the CoreQ Short Stay Discharge Measure in a Future SNF QRP Program Year

CMS requests information on including the CoreQ Short Stay Discharge measure in a future SNF QRP program year. Inclusion of this National Quality Forum (NQF)-endorsed measure will provide a score of patient satisfaction based on 4 items including how well the patient felt his care needs were met and how well the patient felt his discharge needs were met.

LeadingAge supports inclusion of the CoreQ Short Stay Discharge measure in future SNF QRP program years. Currently, patient satisfaction is a missing, vital component to evaluating the quality of care provided in a SNF. Data obtained from the CoreQ would be a useful starting point in advancing a SNF's quality of care goals by highlighting areas of competence and areas for improvement. As this measure would be based on patient engagement and participation, we recommend establishing both a minimum number of surveys policy as well as a waiver for small providers.

SNFs should encourage patients to complete surveys but may have very little influence on participation outcomes. Similarly, a patient's choice to participate or not participate in the survey is not a reflection of the quality of care provided by the SNF. SNFs should not suffer skewed data based on low participation rates or a low volume of stays.

CMS will further need to consider how to implement this measure with the least burden upon providers. SNFs continue to operate under emergency conditions related to the COVID-19 public health emergency and the future remains unpredictable. Implementing a patient satisfaction survey measure would either require the SNF to assign new tasks to an already stretched workforce, or to contract with a vendor when providers are already operating on a deficit to cover increased cost of care, supplies, and labor.

Skilled Nursing Facility Value-Based Purchasing Program: Proposal to Suppress the Skilled Nursing Facility 30-Day All-Cause Readmission Measure for the FY 2023 Program Year

CMS proposes to suppress the Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) for FY 2023 program year as a result of the continued public health emergency (PHE). The measure was suppressed in FY 2022 for scoring and payment purposes and a measure suppression policy, including 4 measure suppression factors, was finalized in response to the COVID-19 PHE. For FY 2023, CMS proposes suppressing the measure once again for scoring and payment purposes under measure suppression factor #4: Significant national shortages or rapid or unprecedented changes in healthcare personnel and patient case volumes or facility-level case mix.

As was finalized in FY 2022, CMS proposes for FY 2023 to utilize the previously finalized performance period FY 2021 and baseline period FY 2019 to calculate risk-standardized readmission rates. All participating SNFs will be assigned a performance score of 0, resulting in identical performance scores and identical incentive payment multipliers. Participating SNFs' adjusted federal per diem rate would be reduced by 2%, then 60% would be awarded back to each participating SNF.

LeadingAge supports the proposal to suppress the SNFRM for FY 2023 under measure suppression factor #4 but urges CMS to increase the payback percentage to the full 70% allowable by statute. SNFs continue to struggle financially due to the COVID-19 PHE and rising costs of care, supplies, and labor. The 60% incentive was finalized in FY 2018 under considerably different circumstances and as the needs of SNF patients, the expectations of care provision, and the realities of the economy all change, our payment systems must be responsive.

Skilled Nursing Facility Value-Based Purchasing Program: Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization Measure

CMS proposes to adopt the Skilled Nursing Facility (SNF) Healthcare-Associated Infections (HAI) Requiring Hospitalization measure with the FY 2026 program year. This claims-based outcome measure is currently in use in the SNF Quality Reporting Program and estimates the risk-standardized rate of HAIs that are acquired during SNF care and result in hospitalization.

LeadingAge conditionally supports the inclusion of the SNF HAIs Requiring Hospitalization measure in the SNF VBP for the FY 2026 program year. This measure is an important indicator of quality in a SNF and has the added benefit of posing low burden on the SNF, being a measure that is claims-based and one with which SNFs are already familiar due to its inclusion in the SNF QRP program. We note, however, that this measure includes hospitalizations due to COVID-19. Given the transmissibility of COVID-19 and relative unpredictability of COVID-19 source exposure, particularly given the inability of a nursing home to enforce source control and prohibit physical contact between residents and visitors, we recommend that CMS update

specifications of this measure to incorporate a risk-adjustment or exclusionary criteria for COVID-19 infection.

Skilled Nursing Facility Value-Based Purchasing Program: Total Nursing Hours Per Resident Day Staffing Measure

CMS proposes to adopt the Total Nursing Hours Per Resident Day Staffing (Total Nurse Staffing) measure for FY 2026. This structural measure would utilize data from the payroll-based journal to calculate total nursing hours per resident day with a performance year beginning FY 2024.

LeadingAge proposes to delay the finalization of this measure to the FY 2024 SNF PPS rule. While we recognize the importance of measuring staffing and note that the total nurse staffing will be included in the 5-star Quality Rating System on Care Compare beginning in July 2022, we cannot support a pay-for-performance program measure during a recognized staffing crisis. The nursing home reform agenda released by the Biden Administration in February 2022 calls for a nation-wide, inter-agency campaign to improve recruitment, training, retention, and transition of workers through long-term care. The report released by the National Academies of Sciences, Engineering, and Medicine, released in April 2022 made several recommendations for federal action to address the staffing crisis. We must see real movement on this issue before we can tie performance to reimbursement.

Skilled Nursing Facility Value-Based Purchasing Program: Request for Comment on the Inclusion of Staffing Turnover Measure and COVID-19 Vaccination Coverage among Healthcare Personnel Measure in Future Program Years

CMS requests comment on including a Staffing Turnover measure in the FY 2024 SNF PPS proposed rule and the COVID-19 Vaccination Coverage among Healthcare Personnel measure in a future undetermined program year. In both cases, these measures would be added to the Measures Under Consideration (MUC) list.

At this time, LeadingAge opposes the inclusion of the COVID-19 Vaccination Coverage among Healthcare Personnel measure in a future SNF VBP proposal. Much like influenza vaccination, COVID-19 vaccination is an important tool in protecting the health and wellbeing of residents in long-term care and the staff caring for them and public reporting of this measure holds SNFs accountable for providing quality care for the residents.

However, we note that this measure is already reported through the SNF QRP program, on Care Compare, and on various CMS and CDC sites. Inclusion of this measure in the pay-for-performance SNF VBP would be inappropriate given that SNFs would be penalized for something over which they have little control – the ability of their staff to accept COVID-19 vaccination. We note that the measure excludes staff who have medical contraindications to COVID-19 vaccine. Should the measure be adjusted to also exclude those who have received other medical or religious exemptions from the vaccine, LeadingAge would reconsider the proposal.

In regards to a Staffing Turnover measure, we believe, as with the proposal for a Total Nurse Staffing measure, that more time is needed before considering inclusion of any staffing measures in the pay-for-performance SNF VBP program and therefore recommend deferring the Staffing Turnover measure until the staffing crisis has been addressed. We further note, consistent with our previous feedback to CMS on this measure, that the definition of turnover must be re-evaluated.

The current measure indicates turnover when a staff member has a work-gap of 60 days or more. As has been previously discussed with CMS, a threshold of 60 days incorrectly identifies turnover in staff who may be on temporary leave, such as those who have been approved leave to care for a new baby, ill spouse, or aging parent. CMS has stood firm on the 60-day threshold, stating that losing staff for a period of 60 days or more, regardless of the reason, is disruptive to the care provided to the resident.

LeadingAge disagrees with this rationale. A 60-day work-gap does not necessarily equate with disrupted care. The resident's care may be re-assigned to a consistent staff member who is able to carry on seamlessly, causing no more disruption than would be caused by a resident who chooses to relocate within the nursing home to a room or unit under the assignment of a different staff caregiver. Conversely, a staff member who experiences a 60-day work-gap and chooses to return to the nursing home following leave indicates dedication to quality care and commitment to the culture of the nursing home. We urge CMS to reconsider the 60-day threshold for determining staff turnover.

Skilled Nursing Facility Value-Based Purchasing Program: Proposed Case Minimums

CMS proposes a new approach to establishing the minimum number of data elements necessary to calculate performance on a measure and for the SNF to be eligible for a value-based incentive payment (VBIP). While proposed minimums would maximize the number of SNFs eligible for a VBIP, MedPAC's recent review of the VBP program suggests that measure reliability would be stronger at a 60 eligible stay minimum instead of the proposed 25 eligible stays or residents.

In addition, we believe an increasing number of SNFs may have trouble meeting minimums for two key reasons: 1) The percentage of Medicare beneficiaries enrolled in Medicare Advantage plans has reached roughly 47% nationally, but in some counties and regions, it makes up 60-80%, leaving fewer Medicare FFS eligible stays to count for a measure; and 2) nursing homes have had to limit or reduce admissions to their SNF due to staffing shortages. For these reasons, we believe the minimums should be higher and include all-payer data to ensure reliability and not negatively impact smaller providers.

Skilled Nursing Facility Value-Based Purchasing Program: Proposals to Update Scoring Methodology and the Performance Score Scale

CMS proposes to update scoring methodology for the SNF VBP. CMS proposes to allow for a maximum of 10 points on each measure for achievement and 9 points for improvement. CMS would identify the benchmark as the mean of the top decile of SNF performance on the measure during the baseline period and the achievement threshold would be defined as the 25th percentile of national SNF performance on the measure during the baseline period. CMS notes that between 0 and 10 and 0 and 9 points will be awarded to providers for achievement and performance scores, but does not indicate whether these scores will be awarded as whole numbers or decimal numbers. Points would then be summed and normalized to a 100-point scale.

LeadingAge supports normalizing the scores to a 100-point scale but cautions that 10-point and 9-point scales without decimal gradations not only have the potential to disadvantage providers but may not allow for enough variation among scores as compared to a 100-point scale. We further support the proposal to consider weighting measures as more are added to the SNF VBP, but recommend CMS seek additional stakeholder feedback as more detailed and relevant information becomes available.

Skilled Nursing Facility Value-Based Purchasing Program: Request for Comment on the Validation of SNF Measures and Assessment Data

CMS requests comment on procedures to validate SNF VBP program measures, quality measure data, and assessment data. CMS requests feedback on the feasibility and need to select SNFs for validation via a chart review to determine the accuracy of elements entered into the Minimum Data Set (MDS) and payroll-based journal (PBJ).

LeadingAge cautions CMS that any adopted validation procedures should consider the burden that would be imposed on SNFs during this validation process. Recall that a chart review and audit of MDS will require the assistance of clinical staff and interdisciplinary team members whose time is better spent providing quality care to residents. Further, some states, such as Washington state, have a state-level validation process in place already. Additional information is also needed related to how CMS would select SNFs validation. It will be essential for stakeholders to have the opportunity to review and provide feedback on methods of selection to ensure an efficient and effective process and LeadingAge recommends that CMS collaborate with states on validation procedures currently in place to avoid duplicative processes.

Skilled Nursing Facility Value-Based Purchasing Program: Request for Comment on Updating the SNF VBP Exchange Function

CMS requests comment on updating the SNF VBP exchange function to accommodate future measure additions to the program. In the FY 2018 SNF PPS rule, CMS illustrated four possibilities for exchange function forms. The logistic exchange function was adopted at that time, but CMS requests comment on whether to propose a new exchange function or modify the logistic exchange function in future years.

In general, in examining whether to change the exchange function for the SNF VBP, we believe our members would appreciate the ability to understand how their performance scores translate into their value-based incentive payment (VBIP); while retaining the benefit of the logistics function that maximizes the number of SNFs who are able to earn a positive payment adjustment. We are concerned overall with the inherent disadvantages in the current system for small SNFs, those who treat sicker beneficiaries, or those who treat higher proportions of dually-eligible individuals.

We would ask that CMS consider and analyze the MedPAC report on the SNF VBP program and see if there are elements in its Value Incentive Payment (VIP) program that might be appropriate to incorporate into the SNF VBP to ensure more equitable opportunity for all SNFs to achieve a positive VBIP. For example, might the SNF VBP group SNFs into like peer groups based upon their mix of residents of social risk? This peer grouping strategy might incentivize SNFs to take on higher need beneficiaries or those with social risk factors.

Request For Information: Mandatory Minimum Staffing Levels

CMS requests information on revising long-term care regulatory requirements to establish mandatory minimum staffing levels. This request for information is connected to the nursing home reform plan announced by the Biden Administration in February 2022, Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes, in which it was announced that CMS would conduct a study to determine the level and type of staffing needed to ensure safety and quality care and propose minimum staffing standards within one year. CMS states that this request for information will help inform policy decisions and provides a number of considerations for feedback.

LeadingAge appreciates the opportunity to provide feedback on this important issue and urges CMS to proceed in a way that is thoughtful, strategic, and realistic. The current workforce shortage in our nation is dire and does not impact nursing homes alone. Both the White House agenda and the report from the National Academies of Sciences, Engineering, and Medicine (NASEM), The National Imperative to Improve Nursing Home Quality, cite the need for an extensive, cross-departmental campaign to address recruitment, training, and retention of workers in the long-term care workforce. Ignoring these imperatives and simply imposing a staffing standard without addressing the workforce crisis is illogical and unjustly punishes nursing homes that are unable to meet standards due to factors beyond their control.

Similarly, enforcing a staffing standard while simultaneously siphoning off resources is a self-defeating exercise. One commonly discussed solution to improve workforce recruitment and retention is to pay competitive wages. While we fully support appropriately and adequately compensating the long-term care workforce, LeadingAge reminds CMS that staff wages and benefits cannot be increased when the system is underfunded and SNF payments are being cut. LeadingAge members have reached out to notify us that they are forced to take beds offline,

close down units, or close the SNF altogether because rising costs and inadequate reimbursement result in a service that is no longer viable.

While downsizing the nation's nursing homes might artificially mitigate the workforce crisis, it does an inhumane disservice to the current residents who must discharge from the nursing home and the future residents who will be forced to seek care outside their home communities because the resources no longer exist locally. You get what you pay for and to get quality care from a thriving workforce, CMS must pay adequate reimbursement rates.

Only after investing in staffing improvements, both functionally and financially, should CMS consider how to measure a staffing standard. For ease of interpretation, we address CMS's specific suggestions below in the format of the proposed rule.

Is there evidence (other than the evidence reviewed in this RFI) that establishes appropriate minimum threshold staffing requirements for both nurses and other direct care workers? To what extent do older studies remain relevant? What are the benefits of adequate staffing in LTC facilities to residents and quality of care?

We are not aware of such evidence. LeadingAge feels it is prudent that staffing standards are evidence-based and resulting from current, setting-specific research, such as the staffing studies dictated in the White House reform plan and the NASEM report. Resident acuity has increased over the years, as have the expectations and requirements for nursing home care. COVID-19 has changed the entire healthcare system, nursing homes included, in a way that could not have been predicted and inarguably, it has changed our future. A fresh study, initiated to examine exactly what is intended to be measured and regulated, should form the basis for considering a staffing standard.

What resident and facility factors should be considered in establishing a minimum staffing requirement for LTC facilities? How should the facility assessment of resident needs and acuity impact the minimum staffing requirement?

As recommended in the NASEM report, the unique characteristics of a nursing home should be considered in determining whether staffing is adequate. Factors such as census, resident acuity, and case mix, as well as any particular needs identified in the facility assessment, factor into the unique level and type of staff that would be required to meet the needs of the residents. Noting that these factors could change on a daily basis, it would be advisable to establish benchmarks rather than absolute values in staffing requirements.

Additionally, clinical discretion afforded by the professionals staffing our nursing homes cannot be overlooked. The medical directors, administrators, and directors of nursing are most familiar with the individual resident needs and plans of care, and with the skills and competencies of their staff. These individuals are the experts on staffing their communities and they must have the flexibility to make choices about the staffing that will best ensure safety and quality of care.

CMS must also consider factors such as geographic location and workforce availability, including availability of workforce specific to the position. Rural or frontier locations may have difficulty filling roles based on limited numbers of qualified candidates. More specialized positions, such as infection preventionists, may necessitate sharing staff between nursing homes or other settings. Meeting minimum staffing standards at 2 or more locations could be challenging, particularly if locations are significant distances from one another. Conversely, geographic location may not be an issue for some nursing homes, but an abundance of jobs in other healthcare settings may challenge the nursing home to fill positions.

Is there evidence that resources that could be spent on staffing are instead being used on expenses that are not necessary to quality patient care?

Both the White House initiative and the NASEM report call for greater transparency and accountability around the financial operations of nursing homes. LeadingAge supports this measure that will show the ways in which our nonprofit and like-minded mission-driven members channel available funding back into the nursing home and care of the residents. As CMS examines this data, we urge you to keep in mind that financial operations contribute to quality care in varied ways. Our members tell us that while staffing may be the primary expenditure, capital expenses such as plumbing repairs or upgrading old buildings have a significant impact on the safety and well-being of residents, their families, and staff.

What factors impact a facility's capability to successfully recruit and retain nursing staff? What strategies could facilities employ to increase nurse staffing levels, including successful strategies for recruiting and retaining staff? What risks are associated with these strategies, and how could nursing homes mitigate these risks?

We know that competitive wages have a significant impact on any employer's ability to recruit and retain staff. Our nonprofit and like-minded mission-driven providers, particularly those with high concentrations of residents relying on Medicaid to cover long-term care costs, are at a disadvantage for paying competitive wages while trying to manage costs of care and operations amidst inadequate reimbursement.

One must also consider the changing demands of the workforce. Reevaluation and internal reflection throughout the pandemic have changed the needs and priorities of the workforce at large. Emerging priorities such as flexible work schedules and remote work options may be challenging or outright infeasible for nursing homes, further disadvantaging nursing homes when recruiting amidst a national, cross-sector workforce shortage.

When contemplating factors impacting workforce recruitment, CMS must also consider the impact of a nursing home's ability to train staff. LeadingAge members tell us that opportunities to partner with local high schools, trade schools, and community colleges are invaluable in bringing in new workers, immersing them in the standard of quality expected, and retaining them through exposure to a culture of caring.

Yet nursing homes across the country are prohibited from operating nurse aide training and competency evaluation programs due to arbitrary limitations that may have little to do with the nursing home's ability to train workers to provide quality care. CMS must be mindful in survey enforcement and pursue appropriate remedies that do not unnecessarily limit nurse aide training options.

What should CMS do if there are facilities that are unable to obtain adequate staffing despite good faith efforts to recruit workers? How would CMS define and assess what constitutes a good faith effort to recruit workers? How would CMS account for job quality, pay and benefits, and labor protections in assessing whether recruitment efforts were adequate and in good faith?

During the pandemic, as nursing homes made decisions about operations and states made decisions about assistance related to staffing shortages, rubrics were useful in guiding providers and ensuring all efforts had truly been exhausted. For example, the Centers for Disease Control & Prevention provided guidance on mitigating staffing shortages in healthcare settings, including strategies to be employed at various staffing capacities (conventional capacity, contingency capacity, and crisis capacity).

We caution CMS, though, on a number of factors. First and foremost, when evaluating a good faith effort, assume positive intent. Our non-profit and like-minded mission-driven providers are dedicated to providing quality care and establishing a culture in which we would all choose to live and work. We know that staffing levels impact not only the experience of the resident, but that of the existing staff as well. Inadequate staffing is neither a choice nor an intent.

While examples of checklists and other documents exist that may be helpful in conceptualizing "good faith efforts", applicability of a single federal, or even state-level checklists is limited. We urge CMS to avoid devising overly detailed, exhaustive matrices for determining good faith efforts that force providers to spend more time checking boxes than innovating on ways to address shortages, and waivers must be available for the inevitable circumstances in which adequate staffing cannot be secured.

Finally, remember that factors such as pay and benefits or workforce pool may be beyond a nursing home's control. To ensure the best chance of nursing homes meeting a staffing standard, CMS and other governmental agencies must actively invest in nursing homes through adequate reimbursement, reduced barriers to education, and successful entry into and transition through the long-term care workforce.

How should nursing staff turnover be considered in establishing a staffing standard? How should CMS consider the use of short-term (that is, travelling or agency) nurses?

Turnover is already being measured and reported on Care Compare. Neither turnover nor the use of short-term nurses should factor into a discussion on staffing standards. The goal of a

staffing standard is to ensure that adequate numbers of staff exist to ensure safe, quality care. The care provided by a staff member should not be discredited simply because the individual is an agency or traveling nurse. CMS should recall that staffing agencies and traveling nurses are utilized expressly for the goal of providing care to residents when direct-employ staff are unavailable. Do not enforce a staffing standard, then create arbitrary barriers to meeting the standard.

What fields and professions should be considered to count towards a minimum staffing requirement? Should RNs, LPNs/LVAs, and CNAs be grouped together under a single nursing care expectation? How or when should they be separated out? Should mental health workers be counted as direct care staff?

As noted previously, these decisions should be based on the results of a thorough staffing study that examines the levels and types of staff necessary to ensure safety and quality care. CMS must carefully consider care provided and quality contributed by both direct and indirect staff, while balancing the realistic challenges of how to measure contributions of various types of staff and the relative burden that could result from additional reporting. Further discussion and solicitation of feedback is warranted upon completion of the staffing study.

How should administrative nursing time be considered in establishing a staffing standard? Should a standard account for a minimum time for administrative nursing, in addition to direct care? If so, should it be separated out?

This issue has been explored previously in discussions around total nurse staffing and weekend staffing measures without satisfying resolution. On the one hand, the presence of a nurse with administrative duties may not translate to direct care. For example, the care experience of a resident on a Saturday afternoon is likely not impacted by the presence or absence of the nurse responsible for the Quality Assurance and Performance Improvement program. However, the activities undertaken by this nurse have a significant impact on resident care. In determining whether to include administrative nursing time, one must be clear on what is being measured and why.

What should a minimum staffing requirement look like, that is, how should it be measured? Should there be some combination of options? For example, options could include establishing minimum nurse HPRD, establishing minimum nurse to resident ratios, requiring that an RN be present in every facility either 24 hours a day or 16 hours a day, and requiring that an RN be on-call whenever an RN was not present in the facility. Should it include any non-nursing requirements? Is there data that supports a specific option?

LeadingAge members from states with staffing ratios tell us that these standards are unnecessarily challenging and prescriptive. The variable nature of resident census makes these standards unworkable when a nursing home is on a threshold and admits a new resident. Members offering multiple service lines, including those nursing homes that are hospital-based,

also note the difficulty of inflexible "on-site" requirements. Nursing home residents with access to a registered nurse enjoy the same standard of care whether that nurse is located on a hallway designated as the nursing home or located on a hallway designated as the hospital or assisted living. When considering staffing standards, CMS must keep the overall goal in mind and allow flexibility in how that goal is achieved.

Are there unintended consequences we should consider in implementing a minimum staffing ratio? How could these be mitigated? For example, how would a minimum staffing ratio impact and/or account for the development of innovative care options, particularly in smaller, more home-like settings, for a subset of residents who might benefit from and be appropriate for such a setting? Are there concerns about shifting non-nursing tasks to nursing staff in order to offset additions to nursing staff by reducing other categories of staff?

CMS must consider how nursing home care is innovating, both as a result of the pandemic and in a shift toward more person-centered care. LeadingAge members report implementing assistive technologies during the pandemic as a safety measure, such as in the case of electronic monitoring of vital signs. These innovations reflect improvements in care that would not be captured in a staffing standard.

Similarly, even before the pandemic, members were frustrated by the unwillingness to consider care provided by universal workers. Though this workforce innovation represented a more person-centered approach to care, the difficulty of classifying the worker has resulted in these services being completely overlooked. If the ultimate goal is truly to improve quality care, CMS must consider these and other care innovations in developing staffing standards.

Does geographic disparity in workforce numbers make a minimum staffing requirement challenging in rural and underserved areas? If yes, how can that be mitigated?

CMS must consider geographic disparities in examining ability to meet standards. While the current workforce crisis impacts nursing homes across the nation, some places struggle more than others. Even before the pandemic, LeadingAge members reported difficulty finding staff and in particular registered nurses (RNs). One resource that seems under-represented is the contribution of licensed practical nurses (LPNs). LeadingAge encourages CMS to examine the role of the LPN in its staffing study and explore ways in which this level of nursing staff might be better leveraged in the nursing home setting, particularly in light of the strain on the RN workforce.

LeadingAge cautions CMS to be mindful of other factors as well. Long-term care positions are less sought after than other healthcare settings so a nursing home's struggle to hire staff might be more a product of an abundance of healthcare jobs in the area rather than a straight-forward staff drought.

What constitutes "an unacceptable level of risk of harm?" What outcomes and care processes should be considered in determining the level of staffing needed?

We implore CMS, once again, to look to the data in answering this question. One would expect that these factors would be determined prior to implementing the staffing study and staffing standards would be based upon the results of that study. LeadingAge further advises CMS to consider how identified outcomes and care processes could inform a re-evaluation of quality measures reported on Care Compare, including those utilized in the SNF Quality Reporting Program and Value-Based Purchasing program.

Thank you for consideration of LeadingAge's comments on this proposed rule and future minimum staffing standards. We welcome any follow-up questions or discussion. Please do not hesitate to reach out to Jodi Eyigor jeyigor@leadingage.org.

Sincerely,

Jodi Eyigor
Director, Nursing Home Quality & Policy