June 2, 2023

Centers for Medicare & Medicaid Services (CMS)
Department of Health & Human Services (HHS)
Attn: CMS-1779-P
PO Box 8016
Baltimore, Maryland 21244-1816

Dear Administrator Brooks-LaSure:

LeadingAge appreciates the opportunity to comment on Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2024. We value the comment and rulemaking process by which stakeholders help shape policy and submit our comments to the Centers for Medicare & Medicaid Services (CMS) on behalf of our 2,000 mission-driven nursing home providers who strive to provide high quality nursing home care every day to our nation's seniors.

Payment Updates

CMS proposes a 3.7% update for Fiscal Year (FY) 2024 based on a 2.7% market basket increase and 3.6% forecast error adjustment, less a 0.2% productivity adjustment and 2.3% decrease for phase 2 of the Patient-Driven Payment Model (PDPM) parity adjustment. While LeadingAge is pleased that the proposed update is not wildly inconsistent with previous years' updates, we remind CMS that additional expenditures continue to be required of nursing homes and are disappointed that payment updates do not reflect these expenses. For example, despite the end of the public health emergency (PHE), SNFs will continue to invest in personal protective equipment (PPE) and testing supplies related to COVID-19 to comply with recommendations from the Centers for Disease Control & Prevention (CDC). SNFs will additionally expect to purchase PPE at higher rates than in the past as they work to implement recommendations from CDC around enhanced barrier precautions to prevent transmission of multidrug-resistant organisms in nursing home residents.

SNFs can expect higher labor and operational costs related to new or enhanced requirements such as water management programs and emergency preparedness activities. Most pressingly, SNFs will incur higher staffing costs related to the pending minimum staffing standards for long-term care. Not only will SNFs be responsible for the costs of recruiting additional staff in a scant workforce, but SNFs will also be expending greater financial resources to retain new and existing workers in compliance with staffing standards. Recognizing that these costs impact the entire nursing home, including SNF residents, consideration of these costs must be included in payment updates moving forward.

Skilled Nursing Facility Quality Reporting Program

CMS proposes multiple changes to measures utilized in the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP). We support CMS's attempts to maintain program measures that reflect quality and efficiency. LeadingAge supports proposals to remove the measures Application of Functional Assessment / Care Plan, Change in Self Care Score, and Change in Mobility Score in favor of measures that more accurately reflect quality and distinction among performance. However, LeadingAge is concerned by proposals to adopt measures in which the measure concept or the measure specifications are reflective of factors and conditions other than nursing home performance. These concerns are outlined below according to measure.

COVID-19 Vaccination Coverage Measures CMS outlines proposals related to 2 measures of COVID-19 vaccination coverage. First, CMS proposes to modify the existing measure COVID-19 Vaccination Coverage among Healthcare Personnel to measure the percentage of healthcare personnel who are up to date with COVID-19 vaccination. Second, CMS proposes to adopt a new measure, COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date, for FY 2026. LeadingAge recognizes the importance of COVID-19 vaccination to protect the health and wellbeing of individuals living and working in nursing homes but does not support the use of these 2 measures in the SNF QRP. Both measures as currently written reflect personal choice, represent outcomes over which the nursing home has no control, and in the case of the resident vaccination measure, provide information that is less useful than information that is already available to the public.

Nursing homes are required to educate residents and staff on the importance of COVID-19 vaccination, including the importance of staying up to date, and to offer vaccination or provide assistance accessing COVID-19 vaccination for residents and staff who choose to accept the vaccine. Once these efforts have been made, there is very little more that the nursing home can do to influence vaccination rates. As we have seen across the country over the past 2 years, many factors influence an individual's decision about COVID-19 vaccination.

Quality care is not measured by perpetuating the patriarchal "Doctor Knows Best" attitude whereby care and treatment are dictated by the physician, care team, or employer. The Biden Administration and CMS acknowledged this when deciding to end the COVID-19 vaccine mandate for healthcare workers and federal employees with the public health emergency. Quality care is measured by adopting true person-centered care practices and respect for individuals that empower residents and staff to make choices about what is important to them and support them as they manifest these choices. To claim that nursing home quality is measured by how many residents and staff make the choice that CMS wants them to make is a complete disregard of the individual's choice and CMS's claim in the proposed rule that "SNFs could choose to administer the vaccine to the resident prior to discharge" seems to indicate that vaccination is a SNF's choice, not a resident's choice.

In addition to failing to measure the quality of nursing home care, the resident vaccination measure further fails to measure the quality of the nursing home environment. In the proposed rule, CMS states that public reporting of the resident/patients who are up to date measure "would provide residents and caregivers, including those who are at high risk for developing serious complications from COVID–19, with valuable information they can consider when choosing a SNF." This is simply not true. As proposed, the measure tells the percentage of discharged short-stay residents who were up to date with COVID-19 vaccination at the time of discharge in a given quarter. In other words, the measure reflects a small portion of the total resident population that is generally not segregated from the broader population, and that no longer resides in the nursing home. The measure tells nothing about risks to potential residents due to the vaccination status of the individuals with whom they will be living and interacting. This information is in no way beneficial to individuals considering SNF care for themselves or a loved one.

LeadingAge is also concerned about the reporting processes outlined for both measures in the proposed rule. CMS proposes that the data for the resident vaccination measure would be collected from a yet-to-be-introduced data element on the Minimum Data Set (MDS). This represents a duplicative process, as resident vaccination status is already reported through the National Healthcare Safety Network (NHSN) system. While the data reported in NHSN is aggregate data rather than the individual-level data that would be collected through an MDS-based measure, we note that the public reporting of the NHSN data on Care Compare captures the entirety of the actual nursing home population regardless of payer source, providing more valuable information than the discharged SNF patients-only measure proposed for SNF QRP. Adding the proposed measure to SNF QRP as written would add burden through duplicate reporting and yield confusing, unhelpful information.

Relative to the healthcare personnel vaccination measure, CMS states that no changes are proposed for the data submission or reporting process; however, the process outlined in the proposed rule does not reflect the current data submission and reporting process. In the proposed rule, CMS states that data will be submitted through the Healthcare Personnel Safety component of NHSN while currently, it is actually submitted through the Long-Term Care Facility component as part of regulatorily required reporting. Should CMS change the reporting process to the Healthcare Personnel Safety component, it would duplicate the reporting already being done. Additionally, as with the resident vaccination data, staff vaccination data is already publicly reported on Care Compare, thus rendering the SNF QRP measure unnecessary.

CoreQ Short Stay Discharge Measure CMS proposes to adopt the CoreQ Short Stay Discharge measure for FY 2026. With this measure, residents discharged from SNF care would report on satisfaction with their stay. This proposal reflects the first adoption of a customer satisfaction measure to the program, a move of which LeadingAge is

supportive generally. We also note that LeadingAge supported endorsement of the CoreQ Short Stay Discharge Measure when it was a Measure Under Consideration. However, we have concerns about the specifications of and processes related to this measure that CMS has proposed. First, in adopting this measure, CMS would require SNFs to contract with an independent, CMS-approved contractor to administer the CoreQ survey to discharged residents. CMS estimates this contract would cost approximately $4,000 annually but our members who are already contracting with companies to conduct customer satisfaction surveys report the contracts cost more. This additional expenditure is essentially an unfunded mandate that our mission-driven members simply cannot undertake. Should CMS adopt this measure with requirements for third-party contractors, CMS must subsidize the cost of these contracts.

CMS proposes that SNFs would be responsible for submitting resident information files containing approximately 30 fields of data to the contractors on a weekly basis. SNFs that fail to submit at least 75% of data files with a 90% rate of completion will be subject to losing their 2% annual payment update. While we are concerned with the administrative burden on the SNF for submitting this data on a weekly basis, we are additionally concerned with CMS's seeming lack of regard for the resident's right to refuse the sharing of his/her information with the contractor. Nowhere in the proposed rule does CMS discuss obtaining resident consent to share the data, though the data will include both individual identifiers and protected health information. While it seems that the data may be intended to help determine eligibility for participation in the surveys, the extent of the intrusion seems unnecessary. For example, data such as gender, race, ethnicity, payer, HMO or dual-eligibility status, and diagnosis of end-stage renal disease have no bearing on the measure and should not be included in resident information files.

Further, we are concerned that the exclusions outlined in the measure specifications could render an unnecessarily small sample size that would not only marginalize the voice of the consumer but risks the burden of data collection outweighing the benefit of the measure. CMS proposes to add elements to the CoreQ survey that would allow for the exclusion of individuals who receive assistance in completing the survey. Based on the relative limitations of the populations typically served in SNFs, we are concerned that significant portions of otherwise eligible residents will be excluded from the measure simply because an adult child or neighbor assists with completion of the survey. LeadingAge recommends that these exclusions be removed from the measure to allow a more robust sample for resident experience.

Data Completion Thresholds CMS proposes to increase data completion thresholds beginning with FY 2026 SNF QRP from 80% to 90%. This means that beginning in calendar year 2024, SNFs would be required to submit 100% complete data on 90% of assessments. LeadingAge notes that this proposed timeline gives only 3 months between the introduction of the newest update to the MDS in October 2023 to the implementation of the new data thresholds. Understanding the significant changes to

the MDS, we are concerned that 3 months may not provide adequate time for SNFs to adjust and ensure 100% complete data. LeadingAge requests that CMS consider a delay in implementation of the data completion thresholds to allow for reasonable acclimation to the new MDS.

Request for Information CMS requests information on measures or measure concepts that can be utilized to fill identified existing gaps in the SNF QRP. While LeadingAge supports refinement of SNF QRP to focus on measures that best communicate the level of quality provided in nursing home care, we are concerned about the identified gaps and CMS's approaches to filling these gaps. We urge CMS to stick to their own guiding principles of actionability, choosing measures for which the outcomes are truly impacted by the actions of the SNF, and comprehensiveness and conciseness, minimizing additional burden to SNFs related to data collection.

For example, cognitive function is not likely to be easily or meaningfully influenced by the SNF and 2 of the 4 instruments suggested by CMS to measure cognitive function are not currently utilized by all SNFs, therefore creating burden due to additional data collection. Similarly, while a nursing home is reasonably expected to identify and address behavioral and mental health issues, nursing homes are generally not specialized in treating behavioral and mental health issues and outcomes are dependent upon the outside resources available, including services and clinicians, and the individual resident. Cognitive functioning and behavioral and mental health are concepts over which nursing homes have limited control and measures and associated instruments should be chosen carefully.

Skilled Nursing Facility Value-Based Purchasing Program

CMS proposes changes to the SNF Value-Based Purchasing (VBP) program to include modification of one measure to replace one measure, adoption of 4 new measures, modification of program policies to accommodate program expansion, and the adoption of a Health Equity Adjustment. LeadingAge supports expansion of the SNF VBP program but has concerns with specific measures proposed, as outlined below.

SNF Potentially Preventable Readmissions CMS proposes updating the SNF Potentially Preventable Readmissions after Hospital Discharge (SNFPPR) measure by modifying the outcome observation window from a fixed 30-day window following acute care hospital discharge to the entirety of the SNF stay and changing the time allowed between a qualifying prior proximal inpatient discharge and SNF admission from one day to 30 days. The modified measure would be renamed the SNF Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure and would replace the SNF 30-Day All-Cause Readmission measure (SNFRM). LeadingAge has concerns about the specifications of this measure. While we support the modification of the outcome observation window to include the duration of the SNF stay, we are concerned about the potential to erroneously contribute potentially preventable readmissions to the SNF when the readmission outcome is due to exterior factors. For example, as with the

previous version of the SNF PPR and SNFRM, we are concerned that a SNF could be penalized for potentially preventable readmissions that occur as a result of patients being discharged prematurely from the hospital to the SNF.

Additionally, with the expansion of the time allowed between a qualifying prior proximal inpatient discharge and SNF admission, we are concerned that SNFs could be penalized if a resident is readmitted to the hospital from the SNF based on a condition that initiated or worsened during the interim period that a patient spent at home or in a lower level of care between the inpatient discharge and the SNF admission. We encourage CMS to reevaluate this measure to ensure these mitigating factors are risk-adjusted or excluded from this measure.

Total Nurse Staffing Turnover CMS proposes to adopt the Total Nurse Staffing Turnover measure for SNF VBP FY 2026. Reported on Care Compare since 2022, this measure reflects the rate of turnover among all nursing staff including registered nurses (RNs), licensed nurses (LPNs), and certified nursing assistants (CNAs) during a given period. While staffing levels could provide important information about nursing home quality, this is not the right measure for the job. LeadingAge and its members have long expressed disagreement with how this measure is calculated and LeadingAge does not support adoption of this measure for the SNF VBP program.

The measure specifies that staff who have a 60-day gap in days worked are considered turnover. Noting that this 60-day timeframe is shorter than the 12 weeks per year of family/medical leave (FMLA) guaranteed by Department of Labor, this means that CMS counts as turnover staff who have not actually left the nursing home and there is no recompense for staff who return to work following this 60-day gap. CMS has previously stated that a gap in days worked, for any reason, impacts the residents who must adjust to a new caregiver; however, staff turnover is felt differently depending upon the role of the staff member. A resident experiences turnover of a CNA differently than turnover of an RN. Similarly, turnover of a clinical nurse vs. turnover of an administrative nurse each have different impacts on the nursing home community at large.

One must also consider the message communicated by turnover. While high rates of turnover could have negative implications for the nursing home environment, rates of staff who return after a gap in days worked tells a different story altogether. Rates of return after gaps in days worked tells a story of dedicated staff and a nursing home worth returning to. CMS silences this story by failing to adjust the turnover measure for staff who return after gaps in days worked.

Similarly, by focusing on staff turnover, CMS erroneously blames nursing homes for a pervasive phenomenon. Employers across all fields have noted changing workforce habits. Workers desire flexible hours, work-from-home options, and greater autonomy as afforded by contract work. These desires conflict with the traditional model of healthcare staffing. When faced with staffing shortages, as much of the healthcare field is at this time, nursing homes may turn to agency staffing to supplement their workforce.

In many cases, the nursing home has no control over which staff are sent by the agency, which could result in high rates of turnover if nursing homes are frequently supported by different agency staff. In this way, the nursing home must choose between not having enough qualified staff to care for the residents' needs and accepting agency staff at the cost of poor performance on the turnover measure with subsequent financial penalty. With the pending staffing standards expected this spring, the potential for this dilemma could increase. Rather than burying its head in the sand, CMS must acknowledge the monumental transformation the global workforce is undergoing and refrain from punishing nursing homes that take the necessary steps to ensure adequate staffing.

Health Equity Adjustment and Variable Payback Percentage CMS proposes to incorporate a Health Equity Adjustment (HEA) beginning with the FY 2027 SNF VBP program year. This incentive payment would reward SNFs for providing high quality care to underserved populations. CMS proposes a calculation by which SNFs that perform in the top third of a given measure and who serve a population of 20% or greater individuals with dual-eligible status would receive additional points to the normalized sum by which they are awarded VBP program payments.

To incorporate this adjustment, CMS proposes to revise the SNF VBP payback percentage to a variable payback percentage by which the payback percentage will not exceed the maximum allowable 70% and the adjustment would not cause any SNFs who are not eligible to receive an HEA to receive less than they would were the HEA not in place. LeadingAge supports these proposals. We feel it is important to advance health equity and appreciate CMS's efforts to implement the adjustment in a way that does not unfairly impact nursing homes who continue to provide high quality care but serve a population of less than 20% dually-eligible individuals. We note CMS's plan to adjust point values to accommodate future program expansions rather than adjusting the variable payback percentage and will appreciate the opportunity to evaluate and comment as needed in future rulemaking.

Updating Validation Processes for the SNF VBP Program With expansion of the SNF VBP Program, CMS has proposed methods for measure validation. Currently, the SNFRM is validated through audits conducted by the Medicare Administrative Contractors (MACs) and CMS proposes to apply this existing process to all current, proposed, and future claims-based measures. Payroll-based journal (PBJ) data is currently audited by CMS on a quarterly basis and CMS proposes applying this process to all current, proposed, and future PBJ-based measures. LeadingAge supports the proposed application of these 2 existing validation processes.

For assessment-based measures, CMS states that the current MDS validation process is focused on ensuring accurate payment and will not focus sufficiently on data for use in a quality reporting or value-based purchasing program. For this reason, CMS proposes adopting a new measure validation process for MDS-based measures. To validate MDS data used for SNF VBP measures, CMS proposes a validation process by

which up to 1,500 SNFs would have up to 10 medical records randomly selected for audit. SNFs that fail to comply with the request for records or that fail to meet certain validation thresholds through audit will receive a penalty. CMS will propose additional details related to the penalty and the evaluation of the audited medical records in future rulemaking.

LeadingAge supports the adoption of a validation process for assessment-based measures but does not support the application of penalties related to these audits. LeadingAge also notes that while CMS believes submission of 10 medical records is "minimally burdensome", we do not agree and urge CMS to identify ways to validate assessment data that does not take time away from patient care by demanding the attention of nurses for administrative tasks.

Request for Information CMS requests information on health equity approaches for future measures. CMS requests input on indicators and indices that could be used to assess health equity, health equity advancement approaches for adoption in SNF VBP, and domains that could incorporate health equity.

One advancement approach proposed by CMS is applying points to certain measures based on performance among underserved residents. This approach reflects the approach outlined in the proposed Health Equity Adjustment and could be used for identifying both within-facility and across-facility disparities. LeadingAge supports these approaches and recommends additionally 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 is also open to the idea of a new health equity-focused measure, but would need to evaluate the specifics of any measure before determining support.

Civil Money Penalties: Waiver of Hearing, Automatic Reduction of Penalty Amount

CMS proposes a constructive waiver process to replace the written process by which a SNF or nursing home waives its right to a hearing related to a finding of noncompliance and receives a 35% reduction in the civil money penalty amount enforced for that noncompliance. Under current policy, a nursing home must submit a written waiver of right to a hearing to receive the penalty reduction, but through a constructive waiver process, CMS would assume that any provider who has not requested a hearing within the allotted 60-day time frame has waived their right to a hearing and the penalty reduction would automatically be applied. LeadingAge supports this change as proposed. The constructive waiver process will eliminate unnecessary administrative burden for both CMS and the SNF without significantly altering the enforcement process.

Thank you for your consideration of these comments. Should you have any questions or require further information, please reach out to Jodi Eyigor jeyigor@leadingage.org.

Sincerely,

Jodi Eyigor

Director, Nursing Home Quality & Policy

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