May 23, 2024

Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS-1802-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Submitted electronically via http://regulations.gov

Dear Administrator Brooks-LaSure:

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Fiscal Year 2025 (FY25) Skilled Nursing Facilities (SNF) Prospective Payment System (PPS) proposed rule: 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 2025. On behalf of more than 2,000 nursing home members, we submit our comments on proposed payment updates, changes to the Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) and Value-Based Purchasing (VBP) program, and nursing home enforcement as outlined below.

**About LeadingAge:** We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.

## Payment Updates

CMS proposes a 4.1% payment update for FY25 based on a 2.8% market basket and 1.7% forecast error adjustment, less a 0.4% productivity adjustment. CMS also proposes rebasing and revising the SNF market basket to a base year of 2022, and an update to the wage index based on data collected during the 2020 census.

LeadingAge generally supports updates to payment policies based on timely data for a more accurate reflection of stable, current conditions. However, we continue to have concern about the inadequacy of long-term care reimbursement. While this rule is specific to post-acute skilled care, the policies in this rule impact both skilled and long-term care since many nursing homes serve both short- and long-stay residents and changes to provisions such as wage index impact both skilled and long-term care reimbursement policies.

While a 4.1% increase is a welcome increase, we are concerned that this increase still will not adequately capture the increased costs experienced by SNFs. Enhanced barrier precautions, implemented in March 2024, will require increased use of personal protective equipment (PPE), in addition to the continued use of PPE anticipated for the care of residents with COVID in FY25. We also know that although the first phase of minimum staffing standards will not be implemented until May 2026, nursing homes will be working on recruitment and retention now in preparation for those standards and to meet current

requirements for sufficient and competent staff to meet the needs of SNF and long-term care residents. Noting that payment updates are based on past spending, we are concerned about residual effects of the recent PDPM parity adjustment, implemented at a time when costs are increasing. We expect these increased costs to be accurately reflected in FY26 updates and hope that, in the meantime, CMS will work toward policies that support nursing homes with the financial and physical resources needed to meet these increased needs.

Along these lines, we support CMS's proposal to rebase and revise the SNF market basket to a 2022 base year. Recognizing the impact of the COVID-19 public health emergency (PHE) on Medicare costs, we agree with CMS that rebasing and revising the market basket more frequently than the recent historical precedent of every 4 years or so is warranted to more accurately reflect costs faced by SNFs at this time.

We are concerned, however, about the impact of updating the wage index based on 2020 census data. In the proposed rule, CMS describes a great deal of shifting between Core-Based Statistical Areas (CBSAs), impacting the wage indices of nursing homes within those CBSAs. While we support the application of the FY23-finalized 5% cap on changes to wage indices, the necessity of applying that cap is problematic. Financial volatility caused by shifting wage indices, among other factors, poses a major threat to our mission-driven member nursing homes that are already struggling to keep up. We also wonder how CMS will even out the wage indices in future years when the cap has been applied, particularly if subsequent years represent a change of greater than 5%. We ask that CMS keep these vulnerabilities in mind when considering changes to payment policy.

## Request for Information – Updates to Non-Therapy Ancillary Component of Patient-Driven Payment Model

CMS requests feedback on future changes to the non-therapy ancillary (NTA) component of the Patient-Driven Payment Model (PDPM). Changes under consideration include an updated study population and updated conditions and extensive services list and coding methodology. We are supportive of CMS's consideration of necessary updates to PDPM but would need to evaluate available evidence and information to be provided in future rulemaking for any proposed changes.

Generally, we understand the intent to update elements of PDPM such as the study population and coding methodology now that actual PDPM data is available but have concerns about certain aspects of these updates. For example, CMS is considering updating the population study to utilize data from Part A SNF stays with admission dates from FY19-FY22. Recognizing that a portion of those admissions were likely impacted by the COVID PHE and flexibilities, CMS is considering the same exclusion factors that were utilized in the PDPM parity adjustment.

While Part A SNF data under PDPM is certainly preferable data to that which was used in the creation of PDPM, we are curious to know how FY19-FY22 data with its exclusions compares to the data used for the creation of PDPM. Is the COVID-impacted data still considered to be a more accurate reflection of the population? If not, CMS should consider waiting until sufficient data has accumulated that would not require use of COVID-related exclusions.

## SNF Quality Reporting Program

For the SNF QRP, CMS proposes the adoption of four new standardized patient assessment data elements (SPADEs), the modification of one SPADE, and new validation processes for assessment-based

measures and claims-based measures. CMS also requests information on future measure concepts including a vaccine composite measure, depression and pain management measures, and a patient experience / patient satisfaction measure.

LeadingAge recognizes the importance of collecting SPADEs to better serve residents' needs and for identifying and addressing potential issues of equity. However, we feel it is important to reevaluate the utility of collecting this information, particularly compared to the burden of data collection. For example, as it relates to four of the proposed SPADEs – the two food items, the utility item, and the modified transportation item – the SPADEs are look-back items, so responses will not change during the course of the resident's stay in the SNF. These SPADEs should only be collected once, rather than on every assessment.

Additionally, while the interdisciplinary team works together to meet the needs of residents in the SNF, any deficits identified through the collection of the housing, food, utility, and transportation SPADEs would most likely fall primarily to the responsibility of social services. Remembering that the social worker's job is to meet the needs of the resident while in the SNF and to coordinate services for a successful return to community, responses to these SPADEs would neither impact nor be impacted by the SNF stay.

For example, while the SNF social worker can provide education and make referrals for housing instability, food insecurity, utility scarcity, or transportation barriers, the SNF social worker has no control over what happens after the resident has discharged from the SNF and technically, the social work relationship ends upon discharge. The SNF social worker must remain within his/her role as the SNF social worker, not the discharged resident's community social worker. It is likely that a community social worker will be tasked with securing necessary housing, food, utility, and transportation resources and ensuring the implementation of assistance for the discharged SNF resident living in the community. CMS must keep this distinction of role and purpose in mind when considering SPADEs and other data collection.

Additionally, CMS should consider the SNF population when determining necessity of collecting this data. While many SNF residents are admitted from the community for post-acute care with a plan to return to the community upon discharge, other residents receiving skilled care are long-term care residents who will remain in the nursing home after discharging from skilled care. Collecting data on social determinants of health such as housing stability, food scarcity, utilities, and transportation for this population is unnecessary and could skew the data for the population for whom this information is more meaningful. CMS should consider ways to ensure that data collected is necessary and useful, and incorporate strategies that will avoid unnecessary data collection.

LeadingAge supports CMS's efforts to improve data validity through proposed validation processes and appreciates efforts to maintain consistency by adopting validation processes already in use in the SNF VBP program and by the Medicare Administrative Contractors. We further support the provision that SNFs selected for validation in one program in a given year (QRP or VBP) will be validated in the other program for the same year to avoid back-to-back validation cycles. CMS must remember, however, that submitting up to 10 medical records in their entirety is quite onerous and we encourage CMS to continue efforts to streamline validation processes in a way that reduces the administrative burden on nursing homes whose primary responsibility is the care of the residents, not photocopying or uploading medical records.

We are also concerned that CMS continues to state that more information will be made available about assessment-based measure validation processes "in future rulemaking" as proposed implementation dates draw nearer. CMS must share this information as soon as possible and provide ample time for evaluation and feedback prior to finalization and implementation of additional policies and processes.

Related to future measure concepts, we appreciate CMS's efforts to maintain a collection of measures within the SNF QRP that are meaningful and relevant. LeadingAge agrees that information on vaccination, depression, pain management, and patient satisfaction could be useful in evaluating SNF quality but hesitates to support inclusion when specific measures have not yet been identified. For example, a composite vaccination measure could be meaningful or convoluted, depending on the vaccinations included in the measure. Likewise, patient experience could be a valuable measure but issues such as those identified by comments on the patient satisfaction measure proposed in the FY24 SNF PPS rule must be addressed. Lastly, LeadingAge feels that any measures proposed for adoption should be endorsed by the consensus-based entity prior to proposal.

## SNF Value-Based Purchasing Program

CMS proposes several updates to program policies including a new measure retention policy and technical measure updates policy, an expansion of the performance standards correction policy, continuation of the measure minimum policy, and updates to the review and correct policy and extraordinary circumstances policy.

LeadingAge supports adoption of the proposed measure selection, retention, and removal policy. We recognize the necessity of such a policy and appreciate CMS's alignment with the policy already in place for the SNF QRP. Similarly, we support CMS's proposals to apply existing measure minimum and review and correct policies to subsequent years of SNF VBP. We also support CMS's proposal to expand the extraordinary circumstance exception policy to allow for exceptions in situations where the provider can prove that extraordinary circumstances prevented the provider from submitting SNF VBP data.

We are concerned, however, about the proposed updates to processes for requesting extraordinary circumstance exceptions. The rule proposes that the existing form for requesting extraordinary circumstance exceptions will be retired and providers wishing to request an exception will simply email a CMS HelpDesk with the required information. We appreciate that this process will align with the existing process for SNF QRP but request that this information be clearly stated and easily located online and through alternative support systems to ensure that nursing homes that need to request such exceptions can do so easily.

## Nursing Home Enforcement

CMS proposes an expansion of authority to enforce civil money penalties (CMPs) upon nursing homes for noncompliance. Currently, CMS may only enforce either per instance or per day CMPs in a survey, but not both. CMS proposes an expansion of authority that would allow for both per instance and per day CMPs to be enforced for noncompliance in the same survey. Additionally, CMS proposes to allow for multiple CMPs to be enforced in the same survey for the same noncompliance.

For example, per instance CMPs could be enforced for multiple episodes of a specific noncompliant practice, while a per day CMP could also be enforced until the systemic issues leading to noncompliance are addressed. CMS states that, in these situations, per day CMPs could be enforced beginning with the start date of survey to ensure CMP rates are based on noncompliance, not on survey timelines. CMS also

proposes to expand the look-back period on which per day CMPs are calculated to include the last three standard surveys, rather than limiting the look-back period to the most recent standard survey as is currently the requirement.

LeadingAge opposes expansion of CMP authority. Increasing financial penalties without revising the survey process to allow for constructive feedback and educational support will not improve quality of care in nursing homes. CMS continues to labor under the misguided notion that taking money away from nursing homes is the best and only way to bring about compliance. This ignores the obvious fact that taking money away from nursing homes through CMP fines means less money is available for the care and services residents depend on.

CMP expansion means less money for recruiting and retaining qualified staff as nursing homes work toward meeting minimum staffing requirements. Many of our members have expressed suspicion and concern that CMS would propose to increase CMPs only months after announcing that they would be taking money out of the CMP Reinvestment Program to fund the staffing campaign that they purport will assist nursing homes in meeting minimum staffing standards. This leads many to question if a CMP expansion is being used to fund this campaign.

CMP expansion also means less money to train staff to meet increasing needs of residents such as behavioral health needs. It means less money with which to implement quality improvement initiatives and make improvements to the physical environment of nursing homes such as renovating outdated physical structures to improve indoor air quality and accommodate private rooms. More CMPs disadvantage the residents in LeadingAge's mission-driven member nursing homes.

Further, we oppose expanding the look-back period to the last three standard surveys, effectively giving CMS the opportunity to reverse course on practices that were previously determined to be compliant. Particularly noting the vast inconsistencies that exist within the survey process, both within states and among states, allowing for survey determinations to be overthrown in this manner introduces chaos into a system that is already seriously in need of reform.

Rather than focusing on ways to make nursing homes do more with less, CMS should focus on what nursing homes need to actualize improvements. Consistent application of standards and constructive feedback at the time deficient practice is identified does far more to correct processes and improve outcomes than simply slapping a fine on a problem and walking away. CMS often contends that their role is one of enforcement and not quality improvement, but the two need not be mutually exclusive. By examining shortcomings of the current survey process and adopting policies that focus on collaborative learning, CMS will reduce the need for CMPs as a faulty method of exacting regulatory compliance.

Thank you for your consideration of these comments. If you have any questions, please reach out to Jodi Eyigor (jeyigor@leadingage.org) for more information.

Sincerely,

Jodi Eyigor
Director, Nursing Home Quality & Policy