California Hospital Association

June 10, 2022

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

SUBJECT: 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 (Vol 87, No 73), April 15, 2022

Dear Administrator Brooks-LaSure:

On behalf of our more than 400 member hospitals and health systems, including approximately 100 hospital-based skilled-nursing facilities (SNFs), the California Hospital Association (CHA) is pleased to submit comments on the Centers for Medicare & Medicaid Services (CMS) SNF prospective payment system (PPS) proposed rule for federal fiscal year (FFY) 2023.

Market Basket Update

CMS proposes a market basket increase for FFY 2023 of 2.8%. The market basket of 2.8% would be increased by 1.5 percentage points — for a forecast error correction (discussed below) — to 4.3% with this proposal. This is then reduced by the negative 0.4 percentage point "productivity adjustment" required under the Affordable Care Act (ACA). The resulting proposed SNF market basket update equals 3.9% (2.8% plus the 1.5 percentage points for forecast error, less 0.4 percentage points for productivity reduction). **The 3.9% does not include the proposed patient-driven payment model (PDPM) parity adjustment that, as discussed below, CHA strongly opposes.**

CHA is deeply disappointed in the proposed 2.8% market basket update, as it is wholly inadequate relative to the input cost inflation experienced by SNFs. Labor-related costs — based on CMS' own forecast of the Labor Related Share in Table 7 of the proposed rule — make up 70.7% of SNF expenses in FFY 2023. **Analysis of SNF Medicare cost reports shows that the average hourly nursing wage increased by 5.3% and 8.1% respectively in fiscal year ends 2020 and 2021[1].**

[1] https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/2022%20State%20of%20the%20SNF%20Industry%20Report.pdf

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While CHA appreciates that CMS will refresh the market basket update in the final rule with more recent data, we are deeply concerned that the revised update will still be insufficient relative to input cost inflation — particularly for labor. Even before the application of the productivity adjustment (discussed further below) the methodology — based on IHS Global Insight (IGI) data— has failed to keep up with facility cost growth year-over-year. Inflation has reached levels not seen in 40 years,[2] which predates the implementation of the inpatient prospective payment system in October of 1983, on which the SNF PPS market basket update is modeled. It is clear, based in particular on rapidly rising labor costs, that CMS' current method is ill-suited to a highly inflationary environment. **Therefore, we ask CMS to consider other methods to calculate the final rule "base" (before additional adjustments) market basket update that would better reflect the rapidly increasing input prices facing SNFs.** If CMS fails to provide an adequate market basket update and implements the PDPM cut as proposed, CHA is deeply concerned about access to nursing facility services for Medicare beneficiaries.

Market Basket Update – Productivity Adjustment

The productivity adjustment required under the ACA is estimated to be negative 0.4 percentage points. CMS uses the total factor productivity adjustment as calculated by the Bureau of Labor Statistics. The adjustment is calculated, as it has been in the past, as the 10-year moving average of changes in multifactor productivity for the period ending September 30, 2023, based on IGI's fourth quarter 2021 forecast.

CHA believes the assumptions underpinning the productivity adjustment are fundamentally flawed. As such, we strongly disagree with the continuation of this punitive policy — particularly during the COVID-19 public health emergency (PHE). The productivity adjustment to the market basket update assumes that SNFs can increase overall productivity — producing more goods with the same or fewer units of labor — at the same rate as productivity increases in the broader economy. However, providing care to patients in skilled-nursing facilities is highly labor intensive, as CMS' projection of the labor related portion of the federal rate — 70.7% — implies in the FFY 2023 proposed rule.

This level of care must be provided on-site and has a high "hands-on" component. Therefore, SNFs cannot improve productivity using strategies like offshoring or automation that are commonly deployed in other sectors of the economy that produce goods (auto manufacturing) or services (dine-in restaurants that use automated ordering systems to reduce overall staffing count). Further, CHA notes that during the COVID-19 PHE, productivity fell[3] as a result of increased staffing turnover and use of temporary staffing due to the labor shortage.

Given that CMS is required by statute to implement a productivity adjustment to the market basket update, CHA asks the agency to work with Congress to permanently eliminate this unjustified reduction to SNF payments. Further, we ask CMS to use its section 1135 waiver authority to remove the productivity adjustment for any fiscal year that was covered under PHE determination (e.g., 2020, 2021, and 2022) from the calculation of market basket for FFY 2023 and any year thereafter.

[2] https://www.npr.org/2022/02/10/1079260860/january-inflation-consumer-prices-cpi-economy-federal-reserve
[3] https://www0.gsb.columbia.edu/faculty/abartel/papers/human_capital.pdf

Market Basket Update — Forecast Error Correction

In the FFY 2023 rule, CMS proposes to make a positive 1.5% "forecast error correction" to the SNF market basket update. The error correction is related to FFY 2021's market basket update of 2.2%. However, the CMS actuary found that the actual increase was 3.7%. **CHA thanks CMS for identifying the correction and strongly supports it.**

Proposed PDPM Parity Adjustment

In the FFY 2023 rule, CMS asserts that FFY 2020 payments were higher under PDPM than they would have been under the prior system. This assertion is based on an analysis of 2020 and 2021 SNF claims and administrative data that were refined based on feedback CMS received from comments on the FFY 2022 proposed rule. As a result of the refined analysis, CMS proposes to apply a negative 4.6% PDPM "parity adjustment," for a total cut of $1.7 billion in FFY 2023. To further justify the "parity adjustment," the proposed rule cites recent Medicare Payment Advisory Commission (MedPAC) data on SNF Medicare margins in an effort to assert that SNFs can sustain a reduction in Medicare payment of this magnitude.

CHA thanks CMS for the thoughtful refinements to the PDPM parity adjustment analysis. However, we are deeply concerned that CMS did not provide data related to the PDPM parity adjustment in the FFY 2023 SNF proposed rule impact file for stakeholders to understand the effect of the proposed reductions on individual SNFs. As discussed below, we believe that CMS' analysis is incomplete and, therefore, overstates the need for a such an adjustment. Additionally, CMS' attempts to justify a cut that will negatively impact Medicare and Medicaid beneficiary access to nursing facilities by citing MedPAC data paint a woefully incomplete picture of SNF finances. While Medicare margins are on average positive, Medicare is the primary source of payment for only 12% of residents. Medicaid — which does not cover the cost of a resident's stay — covers 62% of residents[4]. Given inadequate Medicaid payment, cuts to Medicare SNF payments will devastate access for all residents, especially in rural and underserved areas of the state.

A recent report from the highly regarded accounting firm Clifton Allen Larson highlights just how precarious nursing home margins are[5]. The ongoing spike in labor costs, coupled with the implementation of the PDPM adjustment, will reduce margins to a median of negative 4.8%. The analysis also finds that 32% to 40% of residents, or about 417,000, are currently living in nursing homes that are considered "at risk" financially[6], — meaning they could be displaced if these financial projections come to fruition. **To protect access to skilled-nursing care for Medicare beneficiaries and nursing facilities for Medicaid beneficiaries, CHA asks CMS to delay the parity adjustment — if it is necessary at all — until the analysis of PDPM data can be further refined to eliminate the impact of the COVID-19 pandemic. We also ask that CMS provide stakeholders with a complete impact file that allows for full economic modeling of this harmful reduction to Medicare payments for SNFs before any reduction in payments is made.** CHA's members strongly believe the shifts in the patient population as a result of COVID-19,

[4] https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[5] https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/2022%20State%20of%20the%20SNF%20Industry%20Report.pdf
[6] Facilities at Financial Risk defined as facilities with operating margins in the lowest quintile of performance based on 2019 industry performance (operating margins < -7.5%)

not alleged behavioral changes in response to the implementation of the PDPM, are driving the need for a "parity adjustment."

The FFY 2023 proposed rule outlines a number of steps CMS has taken — many in response to comments received from the FFY 2022 proposed rule — to isolate and remove the impact of the COVID-19 PHE on the PDPM parity adjustment analysis. These steps include.

- **Creating a "Control Period"**: The PDPM parity adjustment analysis is based on a "control period" created by stitching together two separate date ranges — October 2019 through March 2020 and April 2021 through September 2021 — in an effort to use a time frame that is least impacted by COVID-19.

- **Removing COVID-19 Impacted Stays*:*** As in the FFY 2022 proposed rule, CMS uses a "subset population" for the analysis that excludes patients with a COVID-19 diagnosis in the first or second position on the SNF claim and/or on the Minimum Data Set, or whose stay involved a PHE waiver. The proposed rule states that "10% of SNF stays in FFY 2020 and 17 percent of SNF stays in FFY 2021 included a COVID-19 ICD-10 diagnosis code either as a primary or secondary diagnosis, while 17% of SNF stays in FFY 2020 and 27% of SNF stays in FFY 2021 utilized a PHE-related modification."

- **Attempting to Address Concerns About Case-Mix Shifts*:*** The proposed rule analyzes additional, limited data to support CMS' assertion that the case mix impact of the PHE is minimal. First, CMS provides data on the frequency of stays with depression, cognitive impairment, speech language pathology (SLP) comorbidity, and the average mood score for FFY 2019 and the period after PDPM implementation but before the PHE. Citing this data, CMS asserts that the metrics related to these key conditions increased post-PDPM implementation/pre-COVID-19, spiked further during COVID-19 surges but returned to their post-PDPM/pre-COVID-19 levels during periods of lower infection rates.

Second, CMS provides data on the frequency of stays related to major joint replacement or spinal surgery and orthopedic surgery during FFYs 2019, 2020, 2021, and during the "control period." CMS uses this limited data to assert that the "control period" fully addresses issues related to case mix.

CHA thanks CMS for its herculean attempt to remove the impact of COVID-19 from the PDPM parity adjustment analysis. We particularly appreciate the creativity exhibited by creating a "control period" for this analysis. **However, we do not believe CMS has sufficiently isolated and removed the impact of the PHE on the data used to justify a parity adjustment.** Below, please find CHA's concerns with the analysis used to justify the proposed cut to Medicare SNF payments that will place many of America's most vulnerable citizens at risk of losing access to care — and in some cases housing.

First, CHA is deeply concerned that CMS' subset population still includes additional COVID-19 cases from the beginning of the pandemic, when there was no diagnosis code for the disease and testing supplies were scarce. **Therefore, we again ask the agency to remove any residents with a non-specific respiratory infection diagnosis on the SNF claim in the Minimum Data Set during the period starting January 1, 2020, through March of 2020.** While we appreciate CMS' concern about the volume of patients that would be removed with this adjustment, we believe this targeted adjustment is necessary

given that during this period, access to testing was limited. Further, COVID-19 diagnosis codes were not available for much of this period. CHA also notes — as evidence of the necessity and practicality — of this adjustment that this time frame is covered by CMS COVID-19 waivers related to the SNF quality reporting program and value-based purchasing program[7].

Second, CMS' control period includes the time frame from April 2021 through September 2021. We note that, while this period initially saw lower COVID-19 volumes due to warmer weather and vaccinations, it includes the Delta variant-related spike in cases. This spike dominated three months — a full 25% — of the total "control period" that started in July and crested with over 210,000 new COVID-19 cases[8] reported on September 1, 2021. Given that a substantial portion of the control period is still tainted by the impact of COVID-19, it cannot provide an apples-to-apples comparison of the period prior to the implementation of the PDPM. **Before CMS can implement a payment reduction of the magnitude contemplated, it must develop a methodology that removes the impact of COVID-19 on case mix. Otherwise, any payment reduction implemented will be arbitrary and capricious.**

Third, given the significant decline in SNF volume, we are concerned that CMS' attempts to prove that the case mix for the "control period" is not materially different from FFY 2019 is at best incomplete. The proposed rule validates our concerns about changes in case mix in its discussion of the need to suppress the SNF value based purchasing (VBP) measure by stating[9]:

> *The combination of fewer admissions to SNFs, regional differences in the prevalence of COVID-19 throughout the PHE and **changes in hospitalization patterns in FY 2021**[10] has impacted our ability to use the SNFRM (SNF Readmissions Measure) to calculate payments for the FY 2023 program year.*
>
> *Based on the significant and continued decrease in the number of patients admitted to SNFs, **which likely reflects shifts in utilization patterns**[11] due to the risk of spreading COVID-19 in SNFs, we are proposing to suppress the SNFRM for the FY 2023 SNF VBP program year under Measure Suppression Factor (4): Significant national shortages or rapid or unprecedented changes in: Health care personnel, and Patient case volumes or facility-level case mix.*

We note that a similar rationale was used to support the suppression of the SNF readmission measure in the 2022 SNF PPS final rule given presence of aberrant utilization patterns resulting from COVID-19 in the FFY 2020 data. Additionally, the FFY 2022 proposed rule further supports this concern. Specifically, in it, CMS notes that the "data demonstrated important changes in SNF case mix during the PHE including an 18% increase in dual eligible residents…" Dual eligible residents tend to be sicker and more resource intensive than those who are not eligible for Medicaid, as data in the FFY 2023 proposed rule's discussion of the Request for Information: Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs clearly demonstrates. However, CMS' analysis of the

[7] https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting
[8] https://www.nytimes.com/interactive/2021/us/covid-cases.html
[9] 2023 SNF PPS Proposed Rule, Display Copy, Page 131
[10] Emphasis added.
[11] Emphasis added.

PDPM parity adjustment is woefully silent on the percentage of dual eligible beneficiaries, beneficiaries requiring dialysis, and other key resident cohorts who might skew case mix during the "control period" relative to FFY 2019. **Therefore, we again ask CMS to provide additional data — such as that described above — to allow stakeholders to better understand the changes in SNF patient population from prior to the implementation of the PDPM to the "control period" used for the PDPM analysis.**

While we appreciate CMS' additional case-mix impact analysis, we believe it is still inadequate relative to the burden of proof necessary to justify a payment reduction of the magnitude CMS is contemplating that will jeopardize Medicare and Medicaid beneficiary access to care in nursing facilities.

First, we strongly disagree with CMS' assertion in the proposed rule that, "the large majority of SNF beneficiaries entered into Part A SNF stays in FFY 2020 and FFY 2021 as they would have in any other year; that is, without using a PHE-related modification, with a prior hospitalization, and without a COVID-19 diagnosis." Beyond the fact that 17% of resident stays in 2021 included a COVID-19 diagnosis, we note that only 81% of Medicare residents were admitted to a SNF after a prior hospitalization. This is a decrease of 16 percentage points from FFY 2019. Further, based on the data provided by the proposed rule and summarized in this letter, CHA believes there is ample evidence to suggest that the types of patients using SNFs changed in a manner that would increase their acuity.

Second, CMS provides data on the frequency of stays with depression, cognitive impairment, SLP comorbidity, and the average mood score for FFY 2019 and the period after PDPM implementation, but before the PHE. These limited data appear to show that changes in the measures cited occurred after the PDPM implementation but before the PHE. However, CMS does not provide any data from periods with "lower" COVID-19 infection rates (January 2020 – March 2020, April 2021 – September 2021) for stakeholders to understand the frequency of these conditions during the period impacted by COVID-19 that is included in the "control period." The rule mentions concerns raised by stakeholders about compromised skin integrity; however, it does not provide any data for this condition, leaving stakeholders to speculate about how COVID-19 impacted a condition that has a significant impact on SNF acuity and case mix. **CHA is frustrated by CMS' lack of transparency on these metrics — particularly during the "control period." Before CMS makes any parity adjustment, the agency must make these data available for stakeholders to review and provide comments on to the agency.**

Third, the limited data on "elective" procedures CMS provides in the proposed rule to prove there has been minimal impact on case mix is not compelling. CHA notes that, while the decline in major joint replacement and spinal surgery is only one percentage point from FFY 2019 to the "control period," it actually represents an approximately 16% decrease in joint replacement and spinal surgeries in the overall case mix. Additionally, it is unclear from the proposed rule which MS-DRGs are included in "joint replacement." CHA notes that MS-DRGs 521 and 522 (hip replacement with principal diagnosis of hip fracture with and without MCC) are actually emergent conditions. Medicare beneficiaries who are hospitalized as a result of these MS-DRGs are typically frail and, therefore, more likely to require a SNF stay post-acute discharge. If these MS-DRGs are included in the "joint replacement" analysis, it is not surprising that SNF admissions associated with these MS-DRGs did not decrease more significantly.

CHA's members appreciate the data provided in the proposed rule on changes in "orthopedic surgeries." However, it is unclear whether this is actually an indicator of case mix stability. CMS does not specifically define the types of cases included in this category. We assume it includes emergent cases such as

surgical repair of hip fracture (MS-DRGs 480–482). Again, these common cases typically involve frail beneficiaries and, therefore, we would not expect stays related to surgical repairs of hip fractures to decline in light of the pandemic. Instead, one would expect to see these cases increase as a percentage of the overall case mix, which in fact they did (by approximately 4%). CHA believes the increase in these cases — relative to admissions related to non-emergent procedures — proves that SNFs during the control period were caring for a sicker patient population.

Further, in neither the 2022 nor 2023 proposed rule does CMS address the acuity of the patients who were admitted to a SNF before and after the pandemic began. We have heard from members that, during COVID-19, the patients who were admitted after an inpatient stay due to an exacerbation of a chronic illness were much sicker due to avoiding routine care and an inability to access medications due to fear of picking them up for a pharmacy. As a result, they were more resource-intensive and required longer stays in the SNF. This was particularly true for congestive heart failure and chronic obstructive pulmonary disease. These patients were far sicker when they were admitted to the SNF, which accounts for the increased resource use (and related increase in payments) CMS is observing between the pre-and post-PDPM implementation. **CHA believes that CMS must account for this increase in patient acuity and make the data publicly available for stakeholders to comment on before it can determine whether a PDPM adjustment is warranted.**

Fourth, CHA is deeply concerned that CMS does not provide any analysis of the alleged increase related to the PDPM implementation by the type of facility in the FFY 2023 proposed rule. Given that hospital-based SNFs care for more complex patients and more patients experiencing adverse social determinants of health than freestanding facilities, we believe that applying a uniform adjustment — if one is necessary at all — to all skilled-nursing facilities will only serve to penalize those SNFs that care for the most complex and at-risk populations. **Therefore, CHA asks that before CMS implements a parity adjustment, the agency provide data on utilization differences post-PDPM implementation between hospital-based and freestanding SNFs.**

CHA strongly recommends that CMS complete a comprehensive analysis comparing the "control period" and 2019 SNF Medicare resident populations that thoroughly removes the impact of COVID-19 from the data. The results should be made publicly available for comment before CMS implements any parity adjustment (if one is necessary at all). At a minimum, CHA believes this analysis should examine changes in the percentage of dual-eligible residents, percentage of residents on dialysis, and the average hierarchical condition category score associated with SNF residents from each year. **If in fact this analysis concludes that SNF residents in "the control period" were sicker than in 2019, CHA believes that CMS must adjust the data it uses to calculate the PDPM parity adjustment to reflect this fact; otherwise, CMS will overstate the adjustment.**

Given the sheer number of Medicare and Medicaid beneficiaries who could lose access to care if financially at-risk facilities are forced to terminate operations as a result of these cuts, we believe CMS has an obligation to society to first "do no harm." Therefore, before implementing any PDPM parity adjustment, we strongly encourage CMS to further refine its PDPM parity analysis as described above to completely remove the effects of COVID-19 before taking any action that reduces Medicare payments to skilled-nursing facilities.

Finally, in the proposed rule, CMS discusses both delaying and phasing in the "parity adjustment." However, the agency ultimately proposes to make the entire adjustment in FFY 2023, stating that it has already delayed this cut. **CHA does not believe it would be appropriate to implement a parity adjustment until the analysis described above is completed. Further, if a payment reduction of the magnitude contemplated in the proposed rule is necessary, CHA asks that it be phased in over time.** The duration of a phased implementation would ultimately depend on the size of any necessary adjustment. However, we do not believe that the reduction should exceed 0.5% per year. Therefore, as an example, if 2% is the correct adjustment amount, it should be implemented over four years.

Revised Compliance Date for Previously Finalized SNF QRP Measures

Due to the impacts of the COVID-19 PHE, CMS delayed compliance dates for certain measures previously finalized for the SNF Quality Reporting Program (QRP): two Transfer of Health (TOH) Information measures and five categories of standardized patient assessment data elements (SPADEs), including data elements under the social determinants of health (SDOH) category. Specifically, CMS delayed reporting on these measures until October 1 of the year that is at least two full fiscal years after the end of the COVID-19 PHE. CMS now proposes to revise this compliance date to begin data collection on these measures October 1, 2023, for the FFY 2024 SNF QRP.

CHA urges CMS to reconsider this proposal. Though the acute impacts of COVID-19 have lessened over the course of the PHE, the ripple effects continue to significantly impact SNF operations and their ability to collect and report on such a significant increase in data. The COVID-19 PHE has exacerbated existing workforce shortages — as of March 2022, SNF continue to report high rates of shortages for nursing home staff, with 24% reporting shortages for nursing staff and 26% reporting shortage for nursing aides[12]. Some of these shortages are due to more vaccine-evasive strains of COVID-19 infecting the SNF workforce. One CHA member SNF reported that even with a 90% rate of boosted staff, infections are increasing due to the current Omicron strain, requiring a significant number of staff to stay home. These shortages are also caused by burnout among SNF workers and, as experienced professionals leave the workforce, it will take many years to replace them. As SNFs continue to grapple with industry-wide health care worker shortages, resources are being focused on the services that are most important to direct patient care.

In particular, we are concerned that SNFs will be challenged in meeting the revised compliance dates for the expanded categories of SPADEs. The addition of new SPADEs is expected to increase the length of the Minimum Data Set assessment instrument from 51 to approximately 61 pages — a change that will require significant investments in staff education and training — diverting these resources from direct patient care. This will be especially impactful, as the same staff members for whom SNFs report shortages are those most engaged in data collection on these measures.

CHA remains strongly supportive of measures that address SDOH and believes that, implemented properly, the expanded SPADEs will provide all post-acute care settings with valuable information to address health disparities in their communities. However, we are concerned that if the expansion is rushed, the quality of the data collection could be impacted. CMS notes that a revised Minimum Data Set

[12] https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/

version including the TOH measures and SPADEs will be released in early 2023 and will be accompanied by CMS-sponsored education and training events.

This follows a similar timeline for inpatient rehabilitation facilities (IRF) and long-term care hospitals (LTCH), which begin data collection on these measures and elements on October 1, 2022, following the release of updated assessment instruments in April 2022. While CMS has established a virtual training program, registration for these events quickly reached capacity before many CHA members could attend. Although the sessions will be recorded, we remain concerned that IRFs and LTCHs will be required to begin data collection without the adequate training and technical assistance required to ensure standardized data collection on these important data elements.

We urge CMS to take the time to learn from the first full year of data collection on these measures and elements in the IRF and LTCH settings, so that those experiences could inform provider education and technical assistance in the SNF setting prior to establishing a certain date for SNF compliance. We also urge CMS to ensure that there is adequate time between the release of the revised Minimum Data Set and the compliance date to provide significant technical support and assistance to SNFs to ensure successful data collection.

Skilled-Nursing Facility Value-Based Purchasing Program

For the FFY 2023 SNF Value-Based Purchasing (VBP) Program, CMS proposes to adopt a policy in line with the policy finalized for FFY 2022, which would suppress Skilled-Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM) data for scoring and payment adjustments under the VBP Program to avoid holding facilities accountable for distorted or skewed measure results impacted by the COVID-19 PHE. As a result of this policy, the agency would assign all eligible SNFs a uniform performance score of zero, which would yield a payment adjustment of 1.2% — or 60% of the 2% withhold, which would still be applied across the board.

CHA continues to support the suppression of the SNFRM, which we agree was significantly impacted by the COVID-19 PHE due to several factors identified by CMS in the proposed rule. However, as we discussed in our comments on the FFY 2022 SNF proposed rule and detailed below, we disagree that the statute would not allow CMS to establish a hold harmless approach, under which the full 2% withhold could be returned back to eligible SNFs.

As we've commented previously, CHA believes CMS' proposal violates Congress' intent when it created a SNF VBP Program. The payment reduction under §1888(h)(6) of the Social Security Act is intended to fund value-based incentive payments. The title of the subsection — "Funding for value-based incentive payments" — clearly signals this. What CMS is proposing, as discussed below, is neither a value-based payment in concept nor as described by the plain language of the statute. While one could argue a payment reduction is a form of incentive payment, there would need to be some methodology — which is lacking in CMS' current proposal — to differentiate high-performing from low-performing SNFs. Additionally, Congress' choice of the word "funding" implies that some participants should receive a positive payment adjustment as a result of the SNF VBP Program. Otherwise, there is no need to "fund" a payment reduction if Congress only intended to mete out penalties as a result of the SNF VBP Program. This logic is clearly borne out in section §1888(h)(5)(C)(ii)(II)(cc) of the Social Security Act, as discussed in detail below.

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

Finally, the Social Security Act at §1888(h)(5)(C)(ii)(II)(cc) states: *in the case of skilled nursing facilities in the lowest 40 percent of the ranking under paragraph (4)(B), the payment rate under subparagraph (A) for services furnished by such facility during such fiscal year shall be less than the payment rate for such services for such fiscal year that would otherwise apply under subsection (e)(4)(G) without application of this subsection.*

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

Due to the unresolvable issues arising from the COVID-19 PHE CMS describes in the FFY 2023 proposed rule with the 2021 Skilled-Nursing Facility Readmissions Measure data, the agency clearly cannot use it to calculate the SNF VBP Program incentive payment. As described above, Congress clearly only intended for CMS to reduce the SNF adjusted federal per diem by 2% if it was going to use those funds to make a value-based incentive payment as calculated according to the statute. This includes limiting SNFs that receive a negative adjusted federal per diem to those in the lowest 40% of the SNF VBP Program performance ranking. CMS at CFR 413.338(d)(4)(iv) asserts that it "… may grant exceptions to SNFs (from the SNF VBP Program)[13] without a request if it determines that an extraordinary circumstance affects an entire region or locale." CHA notes that the singular use of region or locale does not preclude the plural in regulatory construction. **Given that the PHE makes it impossible for CMS to use 2021 SNF Readmissions Measure data to rank SNF performance and calculate a value-based incentive payment as required by statute, CHA asks CMS to use the authority it asserts at CFR 413.338(d)(4)(iv) to grant all SNFs an exemption from the adjusted federal per diem reduction at §1888(h)(6) of the Social Security Act.**

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

Technical Updates to the SNFRM to Adjust for COVID-19 Patients

Due to the high prevalence of COVID-19 in SNF patients and the demonstrated impact of history of COVID-19 on readmission rates, CMS proposes to update the technical specifications of the SNFRM to account for patients with COVID-19. Beginning with the FFY 2023 program year, patients diagnosed with COVID-19 at any time within 12 months prior to or during the prior proximal hospital stay will remain in the measure's cohort, but CMS will add a variable to the risk adjustment model that accounts

[13] Added for context

for the clinical differences in outcomes for these patients. **CHA strongly supports this proposal. We appreciate that CMS recognizes the long-term impacts that COVID-19 has on patient health, as well as readmission rates. We also encourage CMS to continue to review data and potentially further refine its risk adjustment as more is learned about the impacts and prevalence of long COVID-19.**

Proposed Measure Additions for Future Years

The Consolidated Appropriations Act of 2021 authorized the addition of up to nine new measures in the SNF VBP Program. As such, CMS proposes to adopt two new quality measures for the program beginning with the FFY 2026 program year: Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization and Total Nursing Hours per Resident Day Staffing. CMS also proposes to adopt an additional measure, Discharge to Community, beginning with the FFY 2027 program year.

CHA has long supported the addition of new measures to the SNF VBP Program, with a focus on evidence-based measures directly reflective of provider influence, such as measures of patient safety, mortality and complications, appropriateness of care, and outcomes including functional independence, improvement, or maintenance. CHA provides comments on the specific proposed measures below.

SNF Healthcare-Associated Infections Requiring Hospitalization

CHA agrees that preventing infections is a top priority for SNFs; however, we are concerned that this measure as specified will not produce timely, accurate, or actionable information for SNFs to improve their infection control practices, and we urge CMS not to adopt the proposed measure for the SNF VBP Program. As a claims-based measure — which necessitates a multi-year lag between when the claims are submitted and when the data are used to inform measure performance — we do not believe the measure provides SNFs with the information needed to identify which patients are infected and take action to improve infection-control practices to protect other patients and staff from infection on a timely basis.

In other Medicare quality reporting programs, health care-associated infections (HAIs) are reported via the National Healthcare Safety Network using chart-abstracted surveillance data. These data are based on specific clinical indicators gathered using detailed instructions about what cases to include (or not) in the denominator, as well as clinical definitions that only an infection prevention expert can interpret. This scientific process ensures data integrity and provides analytic tools that enable each facility to assess progress and identify where additional efforts are needed.

CHA is also concerned that the measure is not constructed to detect all HAIs, but just those that result in hospitalization and can be identified in the claims. To be included, a SNF patient must go from the SNF to an acute care hospital, and the hospital must submit a Medicare claim indicating both that the HAI was the principal admitting diagnosis and the patient had the HAI at the time of admission. This measure construction is likely to miss some patients who were hospitalized with an underlying HAI, and it ignores HAIs that did not result in hospitalization but should still have been preventable. Successful HAI reduction efforts depend on the rapid and timely identification of infections so that their underlying causes can be addressed before they result in morbidity or mortality — patients and providers cannot afford to wait two to three years to have claims-based data inform HAI reduction efforts. **As such, we do not believe performance on this measure will adequately assess HAIs in SNFs, nor will it provide SNFs with the timely data necessary to improve their infection control practices and performance under the VBP Program, and we urge CMS to not finalize its use in the SNF VBP Program.**

Total Nursing Hours per Resident Day Staffing Measure
CMS proposes to add a structural measure that uses auditable electronic data reported to CMS' Payroll Based Journal system to calculate total nursing hours per resident day. CHA agrees that sufficient staffing levels are critical to quality and clinical outcomes, and we do not oppose the inclusion of a measure that assesses staffing within the SNF VBP Program.

However, it is unclear to us how performance on this measure will be assessed and how CMS will score SNFs relative to each other to assign performance scores under the VBP Program. In addition, we note our earlier comments on the significant challenges facing SNF staffing resources, as we expect the impacts of the COVID-19 PHE will reverberate for years. Because these impacts may affect various regions and facility types differently for years to come, the ability to assess performance on the measure under the VBP Program could be a challenge. **We urge CMS to provide additional information on how it intends to assign VBP performance scores based on a simple average rate of total nurse staffing per resident per day in a one-year performance period in the final rule.**

Discharge to Community
CMS proposes to add the Discharge to Community measure for the SNF VBP Program beginning with FFY 2027. The Discharge to Community measure assesses the rate of successful discharge to the community from the SNF setting, using two years of claims data, and is risk-adjusted for multiple variables. **As a claims-based outcome measure, CHA appreciates that this measure assesses important outcomes that can be influenced by SNF interventions and discharge planning processes, with minimal data reporting burden. We support its adoption in the SNF VBP Program.**

Requests for Information – Infection Isolation

CMS responds to stakeholder concerns about the definition of "infection isolation" as it relates to patients being cohorted due to either the diagnosis or suspected diagnosis of COVID-19.
Current criteria for coding include provisions that the patient has an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or droplet transmission, requires precautions above and beyond standard precautions, is in a room alone (i.e., not cohorted), and must remain in their room, requiring that all services be brought to them. Being coded for infection isolation can have a significant impact on the Medicare payment rate to reflect the relative costliness of treating a patient who must be isolated due to an infection.

The unique nature of the COVID-19 pandemic is such that SNFs have been compelled to develop and implement new, costly operational procedures to address care needs. In addition to isolating infected patients, it is also necessary to separately house other patients with suspected exposure for a quarantine period. The transmissibility of the virus and the sheer volume of infections precludes the ability of facilities to house all infected or suspected patients without roommates, while at the same time requiring the elimination of group activities. Enhanced precautions and provision of services to patients in their rooms has been required for all patients and residents, not only those with active infection status. As a result, SNFs have incurred, and continue to incur, significant costs for additional staffing, facility modification, supplies, and personal protective equipment to ensure that both infected and non-infected patients receive safe care.

The current criteria for payment adjustment for infection isolation are inadequate to address these unique circumstances. We are gratified that CMS is considering this issue and strongly support changes to allow the inclusion of cohorted patients. Moreover, we believe that the relative increase in resource utilization for cohorted patients is similar to that for individual patients in isolation. The primary drivers of increased costs in both cases are the overall increase in staffing that is required to attend to patients in their rooms, as well as increased costs for PPE and other facility-wide supplies that are necessary to prevent further transmission.

CHA strongly urges CMS to expand the coding criteria to allow the inclusion of cohorted patients in coding for infection isolation. Moreover, CHA believes that the relative resource utilization associated with each patient housed in a cohorted room, as compared with a single patient with an active infection, is similar.

RFI — Revising LTC Facilities to Establish Mandatory Minimum Staffing Requirements

In the current proposed rule, CMS requests data, evidence, and relevant experience on the effects of direct care staffing (nurses, aides, and other professionals) requirements on facility ability to meet resident needs, including maintaining or improving resident function and quality of life.

CHA applauds CMS' consideration of this issue and recognizes the body of research that demonstrates a strong correlation between staffing levels and quality of care. CHA supports policies that will ensure that SNFs have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practical well-being of each resident.

SNFs are a key component of the patient care continuum. As the demographics and needs of our society change and our health care system continues to evolve, SNFs are called upon to care for a wide range of individuals with complex medical needs and/or significant functional disability. In this context, CHA supports the establishment of a minimum standard for nurse staffing, but also believes that any standard must provide sufficient flexibility to allow SNFs to develop and implement staffing patterns that best meet the needs of their specific patient/resident population. CHA encourages CMS to take into consideration the following issues:

- **Standardization***:* While CHA is supportive of staffing standards, we encourage CMS to avoid a "one-size-fits-all" approach. The SNF level of care is unique in that it encompasses two very different types of patient care: 1) post-acute care, for individuals requiring a continued period of medical care and therapy services following a hospitalization for an acute injury or illness, and 2) long-term residential care for persons with chronic medical needs or disability. Resource needs and staffing configurations will necessarily differ between these types of care. For example, as compared to LTC residents, post-acute care patients will require greater numbers of registered nurses and licensed therapy staff to aide their recovery, while LTC residents will need nursing oversight along with extensive personal assistance most frequently provided by certified nurse assistants. While it may be appropriate to establish a minimum standard as a starting point for all facilities, sound policy calls for a clear expectation that staffing will be increased or supplemented as patient/resident needs and acuity require.

- **Congruence with state requirements:** California currently requires a minimum level of nursing hours per patient day, inclusive of registered nurses, licensed vocational nurses, and certified nurse assistants. Additionally, free-standing SNFs in California must have, within a required 3.5 total nursing hours per patient day, a minimum of 2.4 hours per patient day of certified nurse assistant staffing. If CMS proceeds with the establishment of national staffing standards, we encourage the agency to consider establishing a broad framework with limited specific requirements for skill mix or staff type to avoid conflict with state-level requirements and provide flexibility for SNFs to configure staff based on patient needs.

- **Unintended consequences:** The COVID-19 pandemic has underscored — and exacerbated — significant health care workforce shortages. Our member hospitals and SNFs are challenged to recruit and retain qualified personnel of all types, particularly of the types of front-line staff most needed by SNFs, such as licensed nurses, certified nurse assistants, and health care aides.The shortages are particularly problematic in rural areas, where access to SNF services is already more limited. We are concerned that new, increased requirements may lead to limitations in access, especially in underserved areas where recruiting may be more difficult. CHA urges CMS to include sufficient flexibility and timelines to support compliance.

In summary, CHA supports the establishment of a minimum nursing staffing standard for SNFs. However, CHA urges that any future standards take into account the wide range of patient/resident types cared for in these facilities, and that effective and safe staffing levels and configurations will vary accordingly. While CMS may choose to set a minimum standard of nursing hours per patient day across all facilities, we encourage CMS to avoid prescriptive and cumbersome requirements regarding skill mix, while communicating that all SNFs must staff according to patient need and acuity. Moreover, if CMS proceeds with the establishment of a minimum staffing requirement, we request that the implementation timeline 1) include sufficient lead time to allow facilities to recruit as needed and to develop plans to come into compliance, and 2) provide an opportunity for flexibility or waiver on an individual facility basis.

CHA appreciates the opportunity to comment on the FFY 2023 SNF PPS proposed rule. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742, or my colleague Chad Mulvany, vice president, federal policy, at cmulvany@calhospital.org or (202) 270-2143.

Sincerely,

/s/
Megan Howard
Vice President, Federal Policy