May 27, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically to http://www.regulations.gov

Re: CMS-1746-P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022

Dear Administrator Brooks-LaSure:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to comment on this Medicare skilled nursing facility (SNF) payment proposed rule. Our comments will focus on the SNF Quality Reporting Program (QRP), the SNF Value-Based Purchasing Program, and the impact of the SNF payment system on resident care.

SKILLED NURSING FACILITY QUALITY REPORTING PROGRAM (SNF QRP)

Request for Information: Closing the Health Equity Gap in Post-Acute Care Quality Reporting Programs

AARP applauds the Centers for Medicare & Medicaid Services’ (CMS) recognition of and attention to closing the health equity gap in its programs, the existence of which has so clearly been revealed during the COVID-19 public health emergency (PHE). A recent national study found that nursing homes with a higher percentage of African American/Black or Hispanic residents had more than three times as many COVID-19 deaths as those that had a higher percentage of White residents. These facilities should be flagged and then serious efforts put into tackling and resolving the key issues, including staffing shortages and the root causes of the inequities.

AARP firmly believes that ensuring health care equity promotes better quality for all older Americans. We also believe that lessons learned during the PHE can help inform development of measures that will begin to close the health equity gap in post-acute care quality programs. The fundamental importance to good policymaking of collecting data that are accurate, comprehensive, and actionable is unassailable. In this regard, the experience of AARP’s Public Policy Institute in tracking the COVID-19 PHE’s impacts is informative. We have found that
state public reporting of COVID-19 data by race and ethnicity has been fraught with incomplete information, missing data, and inconsistencies in labeling racial and ethnic groups. We strongly recommend that development of any measure that involves race and ethnicity rest on the following principles:

- Data definitions must be valid, clear, and uniformly applied to facilitate data collection and ensure data reliability. A good place to start for developing categories of race is the U.S. Census Bureau;
- Race and ethnicity are distinct constructs and should be separately reported;
- Measure specifications must be clearly designed and readily applied in a consistent manner (e.g., explicit inclusion and exclusion criteria, not implied);
- Rates rather than raw numbers are necessary for proper data analysis and meaningful comparisons; and
- Transparent reporting of the volume of missing data (e.g., percent unknown or otherwise absent data points or responses) is critical to accurate analysis and justifiable conclusions.

We believe that the above principles are adaptable beyond race and ethnicity to many other demographic variables and social determinants of health (SDOH). We continue to support the value of including SDOH as part of the standardized patient assessment data elements (SPADEs) of the SNF QRP. CMS may also want to consider adding education level and income to the data collected regarding SDOH. AARP supports quality reporting by SNFs on all residents regardless of payer as part of advancing equity in quality measurement. Excellent care for all residents should be the desired outcome.

Regarding COVID-19 and to disrupt health disparities across the country more broadly, including those occurring within nursing homes and other long-term care facilities, we need better data. It is important that the federal government gather data and publicly report on COVID-19 cases, deaths, co-morbidities, and testing rates broken down into multiple demographic categories – while protecting patient privacy – including race, ethnicity, age, socioeconomic status, sexual orientation, gender identity, spoken/written language and disability. Data should also include venues such as hospitals, nursing homes, assisted living facilities, residential homes, and other locations. The information, disaggregated for all groups, should also be contrasted with 2019 numbers to truly understand the impact of COVID-19 on all communities. Collection, analysis, and regular public reporting of the detailed disaggregated information will help us effectively understand and respond to the continued spread of the virus in a timely and focused way so that we can minimize the spread of the virus and improve health outcomes now and into the future. Indeed, given what we have learned in this crisis, improved data collection and reporting needs to be an ongoing practice for all long-term care facilities. New proposals and approaches should be monitored with an equity lens and to avoid possible unintended consequences.

Request for Information: SNF QRP Quality Measures under Consideration for Future Years

CMS requests input on a list of measures and concepts for future adoption into the SNF QRP
(Table 27 of the proposed rule). AARP reiterates our previous strong support for the relevance and applicability of patient reported outcomes (PRO measures), as well as for measures of shared decision making, appropriate pain assessment and management processes, and health equity. AARP strongly encourages CMS to build elements related to SDOH into all new measures from their inception, whenever relevant. In addition, we urge the collection and reporting of demographic data to determine how and to what extent quality may vary across different demographic groups. This is important to help determine appropriate and effective interventions to address quality of care issues. We also repeat our prior support for reporting on the SNF QRP measure set for all SNF residents regardless of payer, and we believe this requirement would provide the appropriate baseline data for analyzing potential health inequities.

Finally, in a prior year SNF payment proposed rule, Caregiver Status was identified as a possible standardized patient assessment data element (SPADE) for addition to the program in future years, and CMS sought comment on its importance, relevance, appropriateness, and applicability. AARP strongly supports adding a SPADE to the patient assessment instruments in all the post-acute settings that would identify whether the patient has a family caregiver and to identify that individual to the facility, including contact information (with consent of the resident and the family caregiver). This would ensure that the provider is aware when a beneficiary has a caregiver, who may or may not be the next of kin. The caregiver may have information that is helpful to the provider in caring for the individual, and involving the caregiver during the discharge planning process can help the beneficiary make a smooth transition home or to the next provider setting. In addition, family caregivers can also be vital to ensuring that the individual’s care preferences are communicated and carried out. Creating a Caregiver Status SPADE would also allow for future development of one or more quality measures regarding SNF interaction with and support of family caregivers.

Request for Information: Fast Healthcare Interoperability Resources (FHIR) in Support of Digital Quality Measurement in CMS Quality Programs

CMS asks for input into the agency’s planning for transformation to a fully digital quality enterprise as it relates to the SNF QRP. The agency indicates that exploration is already underway regarding the use of FHIR-based application programming interfaces (APIs) to access standardized assessment data (e.g., SPADEs) from SNF EHRs. AARP appreciates the agency’s planning efforts. As part of this effort, we continue to believe that it is important to strengthen recognition, inclusion, and support of family caregivers in Medicare. Family caregivers should be identified in electronic records (as well as paper records) of the person they are assisting so they can appropriately be part of their loved one’s care team if a care or service plan depends on having a family caregiver. In some cases, this may mean identifying a primary family caregiver and/or other caregivers (including a health care agent or guardian) who take on particular roles or assist their loved ones with specific tasks. Family caregiver identification facilitates engagement, communication, and coordination with the caregiver, as well as the provision of caregiver support, as appropriate. Including this information would be an important step for further development of quality measures related directly to family caregivers. The individual (or their representative, if appropriate) would be given the opportunity to identify their family
Proposed New and Revised Measures for the SNF Quality Reporting Program (QRP)

AARP strongly supports the proposed addition of the COVID-19 Vaccination Coverage among Healthcare Personnel measure (percentage of healthcare personnel [HCP] who receive a complete COVID-19 vaccination course). AARP has called for transparent data collection and reporting of the number and percentage of residents and staff who have been vaccinated by facility and state. This measure would help assess whether SNFs are taking steps to limit the spread of COVID-19 among their staff and residents and reduce the risk of transmission within their facilities. Under the proposed rule, data for at least one week each month would be submitted directly by the SNF to the Centers for Disease Control and Prevention (CDC) monthly and CDC, in turn, would report results quarterly to CMS. Results would be publicly displayed on Care Compare.

Since the publication of this proposed rule, CMS has also issued an interim final rule with comment requiring nursing homes, including skilled nursing facilities, to educate residents or resident representatives and staff about COVID-19 vaccines, as well as offer vaccines to residents and staff when they are available to the facility (with certain exceptions). The interim final rule also requires nursing homes to report weekly to the CDC COVID-19 vaccination status data for both residents and staff. This will give CMS and CDC more complete vaccination data for staff than anticipated when this proposed rule was initially published. We urge CDC and CMS to use this more comprehensive and available data – rather than just one week of data monthly – to develop a more accurate and comprehensive measure of healthcare personnel vaccination.

We strongly support the public display of the COVID-19 vaccination coverage among HCP measure on Care Compare. We also urge the publication of similar data for residents on Care Compare, and more broadly the number and percentage of residents and staff who have been vaccinated by facility and state. This proposed rule and the subsequent interim final rule take important steps, and we urge CMS and the CDC to take the additional steps we have outlined. Information included on Care Compare must be accurate and easy to understand for consumers and their families. This is essential information that may help individuals and families in selecting a SNF, and provide important information for staff, communities, researchers, and policymakers. We also urge that reported data include demographic information to highlight potential disparities similar to those already uncovered about COVID-19 variation within facilities and among residents.

It is also vital that long-term care facilities have consistent access to COVID-19 vaccines, given the ongoing turnover among staff and residents. We urge the federal government to work with states, long-term care facilities, and other entities, as needed, to ensure that facilities can access and administer vaccines on a continuing basis.

AARP also strongly supports the proposed addition of the Healthcare Associated Infections (HAI) Requiring Hospitalization measure. Many of these infections are potentially preventable and signal actionable gaps in care quality, such as high staff turnover and poor infection control.
practices. Further, HAIs that necessitate hospitalization often end in serious complications or even death for this vulnerable population. We note that because this is a claims-based measure, CMS should be able to link the results to demographic information, such as race and ethnicity, providing another opportunity to shine a light on potential health care disparities among SNF residents. Finally, we urge CMS to seek endorsement for this measure by the National Quality Forum (NQF) as soon as feasible.

AARP is concerned about the proposed revision to the Transfer of Health Information (TOH) to the Patient—Post-Acute Care (PAC) measure denominator to eliminate residents who are discharged home under the care of an organized home health service organization or hospice. While we understand the intent is to provide greater precision by eliminating double counting of these discharges in the TOH-Patient and its complementary TOH-Provider measures, we object to a potentially perverse consequence of this revision. Because the TOH-Provider measure tracks whether the current reconciled medication list has been given to the “subsequent provider”, revising the TOH-Patient measure removes the responsibility of the SNF for providing the medication list to the “patient, family, or caregiver” as is specified for the TOH-Patient measure when the patient is transferred to home health or hospice providers. The effect of this measure revision is amplified because CMS intends for the measure to be used in all PAC settings, not just SNFs.

AARP urges CMS to reconsider the proposed revision to the TOH-Patient measure in light of this consequence and to take whatever actions are needed to ensure that the current medication list is provided to the resident and family/caregivers whenever and wherever the SNF discharges a resident (other than through death). Finally, we repeat our prior recommendation that the data element for the TOH-Patient measure should be clear that if a Medicare beneficiary has a family caregiver that individual should receive the medication list if the beneficiary and family caregiver consent, even if it is also provided to the patient. Family caregivers are often involved in assisting the person they are caring for with their medications.

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

SNF 30-Day All-Cause Readmission Measure (SNFRM) Suppression and Scoring Methodology Changes for Fiscal Year (FY) 2022

CMS states significant concerns in proceeding with the usual processes for SNFRM rate calculations and performance scoring due to impacts of COVID-19 and the associated nationwide public health emergency (PHE) on data collection and reporting during calendar year (CY) 2020. CMS proposes to suppress the SNFRM data for program year FY 2022 from its usual use in VBP scoring and determining adjustment factors for incentive payments and reductions. The usual two percent withhold from Medicare payments to SNFs to create the VBP’s incentive pool would be made, but the usual return of 60 percent of those funds to SNFs based on their VBP scores would be replaced by return of 60 percent based on each facility’s withheld amount.
AARP is concerned by the SNFRM measure suppression proposal and related plan for incentive payment and reduction distribution. The proposal essentially disconnects payment from quality, disrupting the intended linkage that defines a value-based program. The distribution plan appears to have risk of rewarding bad actors and penalizing good performers. We have concerns about the agency’s assertion that SNFRM suppression “does not remove the accountability of SNF and nursing facilities…to provide higher quality care and ensure patient safety”. We recognize that CMS is constrained in developing potential options to address the COVID-19 PHE impact in the VBP by the program’s single measure and by the SNF VBP statutory requirements, but we urge that a better option be found. In response to CMS’ specific request for comment, we do not support CMS developing a measure suppression policy for future PHEs under which measure suppression could be activated without notice-and-comment rulemaking.

Finally, we note that you propose to publicly report the SNFRM results as usual – regardless of data suppression – but with a caveat about data quality for the FY 2022 program year. We urge great care in the form and manner you display this material to maximize consumer understanding of the information and minimize confusion.

**Request for Comments on Potential Future Measures for the SNF VBP Program**

Due to enactment of Section 111 of the Consolidated Appropriations Act of 2021, CMS requests input into potential new measures (up to nine) for adoption into the SNF VBP. The new measures would apply to payments for services on or after October 1, 2023. The SNF VBP is one potential element in helping to ensure quality care for older Americans who need SNF care. Congress provided an opportunity to add more measures to the program. We recommend that any and all new measures require data reporting about all SNF residents regardless of payer and that measures incorporate consideration of SDOH whenever feasible and applicable.

We want to comment specifically about several of the agency’s suggested additional quality measures. First, we are generally supportive of Patient Reported Outcomes (PRO) measures. AARP likewise supports the TOH-Provider-PAC measure, though we call attention to our comments above about ensuring residents and family/caregivers receive an updated medication reconciliation list regardless of resident discharge destination. We also strongly support adoption of the percentage of residents receiving antipsychotic medications measure as offering extremely important insights into quality of care across facilities and potentially reflecting adequacy of facility staffing.

If CMS uses resident experience of care measures, AARP strongly urges CMS to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Nursing Home Resident and Family Member surveys instead of the CoreQ questionnaire (as listed by CMS in Table 31) because of the rigor, independence, and lack of bias with which the CAHPS surveys are designed. For example, we note that in CoreQ, the responses to the questions are Poor, Average, Good, Very Good, or Excellent (one negative, three positive, and one potentially neutral). This contrasts with more objective or neutral surveys that include two negative, two positive, and one neutral response. In addition, the Nursing Home CAHPS Survey provides more complete and comprehensive information about a resident’s (or family member’s) experience. Finally,
CAHPS surveys are developed through a public, rigorous, and independent process.

AARP is extremely supportive of measures that assess SNF staffing, including the several Payroll Based Journal elements appearing in Table 31 (i.e., nurse staffing hours per resident day, Registered Nurse staffing per resident day, and total nurse staffing [including RN, licensed practical nurse (LPN) and nurse aide] hours per resident day). CMS should ensure that these are actual hours spent providing direct care to residents. Further, we strongly recommend that CMS consider other staff metrics, including staff turnover. Along with staffing patterns, turnover rates may indicate quality and safety issues as well as equitable and good treatment – or not – of employees by the facility. We note that turnover among clinical and nonclinical staff is particularly disruptive to optimal care for SNF residents with dementia. The importance of data accuracy cannot be overstated. Measures should be constructed to facilitate and ensure accurate reporting. Data validation and audits are other important ways to ensure the veracity of the data.

Finally, AARP urges CMS to consider development of a measure focused on resident “dumping”, the practice of inappropriately or abruptly discharging or transferring a resident, including when a facility no longer wants to meet the resident’s needs. We are hearing about the occurrence of such events with increasing frequency, particularly involving residents with dementia. We encourage CMS to explore this topic with stakeholders with the goal of developing an applicable direct or proxy measure. Factors that CMS could consider include complaints regarding inappropriate discharges and transfers. We understand that facility-initiated transfers and discharges remain a top complaint to long-term care ombudsman programs across the country.

More broadly regarding the SNF VBP program, some skilled nursing facilities are receiving reduced Medicare payments. AARP urges CMS to closely monitor the impact of the SNF VBP program on quality of care and quality of life in nursing homes for both short-stay and long-stay residents. If CMS and/or states observe that the SNF VBP program has adverse impacts on quality, they should take appropriate action to help ensure quality. We also encourage CMS to suggest any legislative or regulatory changes that might be needed to address program issues as they arise.

**PATIENT DRIVEN PAYMENT MODEL (PDPM) IMPACT ON RESIDENT CARE**

On October 1, 2019, CMS implemented the Patient Driven Payment Model (PDPM), a new case-mix classification model that replaced the prior case-mix classification model, the Resource Utilization Groups, Version IV (RUG-IV). We note that in prior comments, AARP indicated that the RUG-IV did provide incentives for SNFs to overuse rehabilitation therapies (physical therapy, occupational therapy, speech-language pathology) by paying more for residents receiving these services than for residents not receiving them. CMS’ analysis in the proposed rule shows the average number of therapy minutes declining from 91 minutes in FY 2019 to 62 minutes in FY 2020 for SNF residents prior to the beginning of the pandemic. However, AARP also notes that CMS’ analysis shows concurrent or group therapy rising from 1 percent of each therapy mode prior to FY 2020 to 32 and 29 percent respectively in the first month of PDPM implementation.
This increase in the use of concurrent and group therapy timed just as the PDPM was implemented is concerning. In prior comments, AARP indicated that individual therapy can best address a specific resident’s care needs. CMS agreed that “individual therapy is the preferred mode of therapy provision and offers the most tailored service for patients.” (84 FR 17635). Yet the data analysis suggests that SNFs responded to the payment incentives inherent in the PDPM by reducing the amount of individual therapy provided and instead substituting group and concurrent therapy. As noted in our prior comments, AARP was concerned about financial incentives for SNFs to under-supply some services and limit care for some residents – in this case, individual therapy.

As we have stated previously, AARP urges that CMS make publicly available information and analysis that shows how the PDPM is impacting SNF residents. It is particularly important to continue monitoring these issues and intervene where necessary to ensure that SNF residents are receiving all of the services they need rather than allowing SNFs to substitute concurrent or group therapy when individual therapy is indicated. While this comment is focused on individual therapy, we believe the analysis should also review whether SNFs are continuing to provide other services needed by their residents, including older individuals who have longer SNF stays. CMS should act quickly to address any emerging problems affecting SNF residents.

Finally, we encourage CMS to use insights and lessons learned from the pandemic regarding the use of technology in nursing homes for virtual visits with loved ones and accessing health care services through telehealth. While not a replacement for in-person visits, virtual visits can be an important lifeline for families, friends, and residents both as a source of comfort and an important safety check. Among the lessons learned are the importance of access to the necessary technology, including videoconference or similar technology to enable residents to see their family and friends, and funding for it; designated staff to facilitate virtual visits with residents (including assisting with the use of the technology and scheduling visits); regular cleaning and disinfecting of devices; and the availability of broadband access. It is also important for facilities to communicate clearly with residents and families about how to access virtual visits.

The use of telehealth in nursing homes during the pandemic has helped ensure more efficient and effective access to health care. It is an effective way to deliver care while preserving physical distancing and minimizing risk of COVID-19 exposure. In addition, telehealth may enable the participation of family caregivers in care delivery with the consent of the resident. This could help with care coordination and continuity, a smooth discharge from a skilled nursing facility, and care at home post-discharge. AARP has supported greater access to telehealth for Medicare beneficiaries. We also note the use of telehealth is a tool meant to supplement, not replace, necessary in-person care.

**CONCLUSION**

AARP appreciates the opportunity to comment on this proposed rule from the perspective of residents and their families. We urge CMS keep the needs of residents and their families front and center as you finalize this rule and make longer-term policy decisions. If you have any
questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs