June 10, 2022

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-1765-P. Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities to Establish Mandatory Minimum Staffing Levels

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 important proposed rule that is vital to the health, safety, and well-being of nursing home residents and important to their family caregivers who may often assist with their loved ones’ care and advocate on their behalf. AARP commends the Centers for Medicare & Medicaid Services’ (CMS) request for information (RFI) on revising requirements for nursing homes to establish mandatory minimum staffing levels, a critical issue for residents and their families. AARP’s comments will address this minimum staffing RFI, equity, the Skilled Nursing Facility (SNF) Quality Reporting Program, the SNF Value-Based Purchasing (SNF VBP) Program, and the impact of payment changes on resident access to necessary care. In general, in this letter, references to nursing homes means skilled nursing facilities participating in Medicare and nursing facilities (NFs) participating in Medicaid. In certain cases, we may refer specifically to skilled nursing facilities (SNFs) participating in Medicare.

RFI – Revising Long-Term Care (LTC) Facility Requirements to Establish Mandatory Minimum Staffing Levels

AARP supports the establishment of mandatory federal minimum staffing levels or standards for nursing homes as a condition of participation to begin and continue in the Medicare and Medicaid programs. As the nation reflects on the one million deaths from COVID-19, it is important to evaluate the reasons that a significant percentage of these deaths occurred in these facilities. The COVID-19 pandemic demonstrates the importance of both adequately trained staff and a sufficient number of staff in nursing homes. Research consistently shows that higher registered nurse (RN) staffing levels are associated with better resident care quality across multiple dimensions of care including fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs) independence; less weight loss, dehydration, and insufficient morning care; less improper and overuse
of antipsychotics; and lower mortality rates. The goal of minimal staffing requirements should be to increase staffing thresholds to at least the levels determined necessary to ensure adequate care. Minimum staffing requirements are one key part of ensuring quality of care when it comes to staffing, as are appropriate training, the competency of staff, recruitment and retention, turnover, consistent staffing, appropriate adjustment of staffing levels to ensure that residents’ needs are met above minimum staffing requirements, and the appropriate mix of staff, among others.

Despite the increased focus on staffing and its importance over the last 20 years to better resident care in nursing homes, AARP continues to be disappointed in the lack of progress made in addressing this issue. In 2016, CMS issued new requirements for nursing and skilled nursing facilities to participate in Medicare and Medicaid. The regulations require that facilities have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure residents' safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. However, CMS set no specific federal, legal minimum amount of time per resident per day requirement or minimum nursing staff to resident ratio per shift. With respect to required nursing care, CMS’ only current requirement is that a nursing home must provide 24-hour licensed nursing service that is sufficient to meet nursing needs of its residents and must have a RN on site for 8 hours per day, 7 days a week. Nursing homes lead with “nursing” in their nomenclature because they depend on RNs and nursing care teams to deliver safe care to their residents. Without an adequate nursing staff, including licensed practical nurses (LPNs), and certified nursing assistants (CNAs) led by a registered professional nurse around the clock, safe care is not possible.

Although there is not a defined minimum staffing level, many stakeholders, including AARP, reference findings from the 2001 staffing study commissioned by CMS on this issue. This study found that to prevent harm or jeopardy to residents of nursing homes a minimum of 4.1 nursing hours per resident day (hprd) in total was needed; this is comprised of a minimum of 0.75 RN hprd, 0.55 licensed practical or licensed vocational nurses (LPNs/LVNs) hprd (1.3 hprd for RNs and LPNs/LVNs combined), and 2.8 certified nursing assistants (CNA) hprd. Results from a 2021 Government Accountability Office (GAO) study (based on 2019 data), however, found that three-quarters of SNFs did not meet the minimum RN and total nurse staffing that the 2001 CMS staffing study identified as needed to avoid quality problems. This finding highlights AARP’s concern that nursing staffing levels in these facilities may be severely inadequate and additional measures are needed to increase staffing overall in the nursing home industry.

The research study that CMS is planning to inform the establishment of federal minimum staffing requirements is important because it would look at care provided in nursing homes today. While the 2001 staffing study conducted for CMS is the source of the current minimum staffing thresholds of 4.1 hprd, that study was completed over 20 years ago and does not reflect the increased acuity of today’s nursing home residents. While the 2001 study should be considered as important information and data,
more weight should be given to current data more reflective of present-day resident care needs and experience. Given the higher acuity of today’s residents, staffing thresholds in a current study may be higher than in the 2001 study.

AARP believes that a broad-based study commissioned by CMS to determine minimum staffing needs is an important step in the process of developing federal minimum nursing home staffing requirements. This should also include an examination of states that have already established minimum staffing ratios and their impact on the quality of care received by beneficiaries. AARP urges CMS to act swiftly to ensure minimum staffing standards. It will also be important to communicate the minimum staffing levels in a consumer-friendly manner, so they are understandable for residents, prospective residents, their families, and the general public.

In addition to our overall comments on this issue, AARP has specific responses to certain questions posed by CMS in its RFI.

**RFI Question 1:** Is there evidence (other than the evidence reviewed in this RFI) that establishes appropriate minimum threshold staffing requirements for both nurses and other direct care workers? To what extent do older studies remain relevant? What are the benefits of adequate staffing in LTC facilities to residents and quality of care?

The relationship between staffing and nursing home care has been well established in the literature and the patterns found in these studies remain as relevant today as when they were published. In a systematic review of 87 research articles and government documents from 1975-2003, the authors found that higher total staffing levels (especially licensed staff) improved quality of care, especially in the areas of functional ability, pressure ulcers, and weight loss. The study also found a significant relationship between high turnover and poor resident outcomes. Given the rise in acuity levels of nursing home residents over time since that 2006 study, the relationship between staffing and quality is even stronger. A more recent study showed a similar finding related to COVID-19; nursing homes with higher RN staffing are strongly associated with fewer COVID-19 related deaths.

Research has established a strong positive relationship between staffing and quality, but it is important to update the 2001 staffing study to determine what is an even more current appropriate minimum nursing staffing standard below which quality would be compromised. The 2001 staffing study commissioned by CMS identified, as discussed above, a daily minimum threshold of 4.1 hours of total direct care nursing time per resident. This study needs updating in light of changes in resident acuity compared with 2001. Given the rise in acuity levels, the total direct care nursing time threshold may be higher than 4.1 hours and the required minimums for the RN, LPN, and CNA may also be higher.

A recent report shows that without federal minimum standards in place, state requirements for nursing home staffing standards varied widely and fell far short of the minimum thresholds identified in the

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2001 staffing study. Only the District of Columbia exceeded the overall level of 4.1 hprd. Of the 36 states that had a total nursing staff time requirement, most states had a standard that ranged from 2.00-2.99 hprd. A smaller subset of these states had specific standards for RNs, LPN/LVNs, and CNAs and only four states exceeded the recommended staffing level of LPNs/LVNs. A uniform federal minimum staffing requirement would help ensure individuals receive comparable nursing home care regardless of the state in which the person resides.

**RFI Question 2. What resident and facility factors should be considered in establishing a minimum staffing requirement for LTC facilities? How should the facility assessment of resident needs and acuity impact the minimum staffing requirement?**

Staffing levels required may vary based on resident acuity, which is important to ensure nursing homes provide the right amount of staffing. We believe CMS should explore this issue when it conducts its new staffing study, but we do not believe that this should hinder the establishment of a minimum nursing care staffing standard. CMS could first establish a numeric threshold based on or factoring in an average across all acuity levels then refine its staffing measures and associated thresholds as it gains more experience. A study could also consider how much time it would take staff to meet the needs of different types of residents with different care needs. The requirement CMS is establishing is an average “minimum” not necessarily the required amount of staffing for a particular resident – those needs should be addressed through the resident’s care plan. Minimum staffing standards should act as floors, not ceilings. Actual staffing levels for any given facility must be adjusted upwards of the minimum staffing requirement as necessary to meet the actual needs of each resident as identified in their comprehensive needs assessments and the actual needs of the facility as determined by the facility assessment under current CMS regulations. Staffing levels should also meet resident needs, whether during the day, in the evening, overnight, or on a weekday or weekend.

**RFI Question 4: Is there evidence that resources that could be spent on staffing are instead being used on expenses that are not necessary to quality patient care?**

There is a need for better transparency and accountability to ensure that funds paid to nursing homes are used for appropriate means, such as for staffing and resident care. AARP supports a federal direct care payment ratio (similar to a federal medical loss ratio) for nursing homes to help ensure that they are devoting sufficient funds directly to resident care, safety, quality, and staff. AARP has also supported provisions pending in federal legislation that would provide funding for the Department of Health and Human Services (HHS) to audit Medicare skilled nursing facility cost reports for more facilities and create a path for HHS to reduce payments to facilities that report inaccurate data. The need for increased transparency and accountability of finances, operations, and ownership is also included as one of the broad goals and areas with recommendations in the National Academy of Sciences, Engineering, and Medicine’s recent consensus study report, *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*. These facilities also received billions of dollars during the COVID-19 pandemic and there has been a lack of transparency on the use of these funds generally.

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The impetus for stronger oversight and reporting is heightened by complex ownership structures, related-party transactions, changes in ownership, and the rapid growth in private equity firm involvement in nursing home ownership. Private equity (PE) firms often have complex ownership structures with less transparency in how funds are used and the extent to which they are used for resident care and staffing. Private equity ownership of nursing homes has been associated with higher costs and increases in emergency department visits and hospitalizations for ambulatory sensitive conditions. Private equity ownership may mean reduced staffing, services, or supplies which may have a negative impact on quality of care.

**RFI Question 5:** What factors impact a facility’s capability to successfully recruit and retain nursing staff? What strategies could facilities employ to increase nurse staffing levels, including successful strategies for recruiting and retaining staff? What risks are associated with these strategies, and how could nursing homes mitigate these risks?

There are many factors that impact a facility’s ability to successfully recruit and retain nursing staff including pay, paid leave, health insurance, other benefits, training paid for by the employer, the quality of the training, work environment and culture, if the staff feel respected and have input into resident care and a clear role on the care team, and adequate staffing. Addressing these issues would help with recruitment and retention. Inadequate staffing is a particular concern, as this places both facility staff and residents in danger. For example, if two staff members are needed to safely transfer or move a resident and one staff person tries to do it because a second person is unavailable, the staff person can risk injury to themselves or the resident. The stress of being short-staffed and not being able to meet residents’ needs or do one’s job sufficiently can take a daily and long-term toll on staff.

AARP believes that establishing a federal minimum nursing staffing requirement would create a safer workplace and make nursing home employment more attractive to RNs and other staff.

**RFI Question 6:** What should CMS do if there are facilities that are unable to obtain adequate staffing despite good faith efforts to recruit workers? How would CMS define and assess what constitutes a good faith effort to recruit workers? How would CMS account for job quality, pay and benefits, and labor protections in assessing whether recruitment efforts were adequate and in good faith?

The acceptable levels of the quality and safety of care provided to residents should not be adjusted on a facility’s ability to obtain staff regardless of good faith efforts to recruit workers. CMS has a range of enforcement activities, including the appointment of temporary management, to ensure prompt compliance based on the severity of the noncompliance and we support the President’s strategy for improving safety and quality of care in nursing homes. In addition, if there are any good faith effort considerations for recruitment of workers, there must be documentation of such efforts and a timeline. If a facility does not recruit workers in the timeframe, they should have to shut down beds and/or cease new admissions. CMS needs to hold nursing homes accountable for their performance which includes

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providing adequate staffing and adjusting the number of residents in a nursing facility to reflect the staffing levels.

RFI Question 7: How should nursing staff turnover be considered in establishing a staffing standard? How should CMS consider the use of short-term (that is, travelling or agency) nurses?

AARP strongly supports CMS efforts to add a nurse turnover rate measure to the SNF VBP program and appreciates the addition of staff turnover measures on Care Compare. It may be challenging to consider nurse staff turnover in establishing a minimum nurse staffing standard, but such turnover should be measured separately as part of the SNF VBP program. Inconsistent staffing due to high turnover is disruptive to the quality of care received by residents. We believe that it is also important that the same staff consistently works with the same residents (consistent staffing). The residents and staff get to know each other, develop a rapport, relationship, and trust, and the staff learns more about what the resident needs on a regular basis, how they like things done, and when there are changes in condition, behavior, or otherwise that may signal something is wrong.

A workforce largely comprised of temporary staff can be a sign of higher turnover, poor management and/or working conditions. Extensive use of temporary workers is a disincentive to staff recruitment and retention. Short-term nurses can help fill temporary staffing gaps in between staff departing and new hires, in emergencies or pandemics, but they are not a long-term solution. There should be incentives to hire as many permanent staff as possible.

RFI Questions 8, 9, and 10: What fields and professions should be considered to count towards a minimum staffing requirement? How should administrative nursing staffing requirement be considered in establishing a staffing standard? How should a minimum staffing requirement be measured? (Questions summarized)

AARP recommends that CMS establish a total direct care nursing hours per resident day (hprd) measure that is the sum of a minimum RN hprd, a minimum LPNs/LVNs hprd, and a minimum CNA hprd. A given nursing home would be required to meet four minimum nursing staff requirements: one total minimum staffing requirement and three minimum staffing requirements allocated across the other three staffing types, similar to the thresholds in the 2001 staffing study. These standards would be established by a new CMS research study. We believe that the time counted toward the minimum staffing requirement must be hands-on direct care, not administrative, activities, meal-prep, janitorial, or social worker time, or non-resident care. While we recognize important administrative work is part of RN or advanced practice registered nurse roles, we believe that CMS should count or acknowledge this time spent by the professionals separately from hands-on direct care provided by nurses. The minimum nursing staffing requirements above could also be accompanied by minimum nurse to resident ratios. See also our answer to Question 14.

AARP recognizes that other professions, such as social workers, rehabilitation therapists, and mental health providers, provide important services to residents of nursing homes. We strongly believe, however, that any measure of other staff should be separate and distinct from the minimum direct care nursing staffing requirement discussed above. We are concerned that some states have included other professions or unlicensed assistants, such as feeding assistants, in direct care staffing measures which dampens or dilutes the effectiveness of having a minimum nursing staffing requirement; AARP does not support this framework for developing a federal minimum staffing requirement. CMS should also
be mindful of resident needs for minimum staffing across a 24-hour day and on weekdays and weekends.

We recognize that any minimum nursing staffing requirements should take into account and consider innovative care models, such as small house nursing homes (Green Houses or others) who may use a universal worker approach. The measures should allow for innovative care in a way that ensures residents get the care they need and there is a consistent measure of such care.

**RFI Question 14: Should CMS concurrently require the presence of an RN 24 hours a day 7 days a week? (Question summarized)**

In addition to the specific direct care nursing hour requirements, AARP also supports requiring nursing homes to have at least one registered nurse or Advanced Practice Registered Nurse (e.g., a gerontological nurse-practitioner), with clinical responsibilities on duty 24 hours a day, seven days a week. The recent consensus nursing home report from the National Academies of Sciences, Engineering, and Medicine (NASEM) includes a recommendation for on-site direct-care RN coverage (in addition to the director of nursing) “at a minimum of a 24-hour, 7-days-per-week basis with additional RN coverage that reflects resident census, acuity, case mix, and the professional nursing needs for residents as determined by the residents’ assessments and care plans.” RNs are essential to quality nursing home care because they bring important skills and competencies not expected from LPNs or CNAs, including oversight of care and resident assessment. For example, GAO found that decreases in RN staffing could lead to higher rates of critical incidents, such as higher hospital readmission and ER rates within 30-days of SNF admission. While almost all SNFs meet the federal requirement for RN on-site for 8 hours per day, we do not believe this is sufficient given the importance of RN staffing and beneficiary quality of care.

**RFI Question 16: Does geographic disparity in workforce numbers make a minimum staffing requirement challenging in rural and underserved areas? If yes, how can that be mitigated?**

AARP believes that a basic principle of a minimum nurse staffing requirement is that it should be uniformly applied regardless of the location of the nursing home. While we recognize that geographic disparities in workforce numbers may make a minimum staffing requirement more challenging in rural and underserved areas, we believe that weakening or lowering the nursing staffing threshold for nursing homes would be inappropriate.

**Patient Driven Payment Model (PDPM) Impact on Resident Care**

As expressed in past comments, AARP remains concerned that the PDPM, implemented in FY 2020, could create financial incentives for SNFs to under-supply some services and to limit care for some residents, particularly for those who are older and have longer SNF stays. As CMS has noted, between

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12 Green House homes, an alternative to traditional nursing homes, are best known for being smaller structures with just 10 to 12 residents that have the look and feel of a “real home.” But they also fundamentally differ in their workforce model, which is designed to improve the quality of work life for all staff, but particularly for the Shahbazim—the Green House home’s direct care team of certified nursing assistants.

13 [https://nap.nationalacademies.org/resource/26526/Nursing_Homes_Recommendations.pdf](https://nap.nationalacademies.org/resource/26526/Nursing_Homes_Recommendations.pdf)

14 GAO-21-408

15 GAO-21-408, GAO found that almost all (99%) of SNFs met this requirement.
October 2019 and December 2019 the average number of therapy minutes SNF patients received dropped from 93 minutes (before PDPM) to approximately 68 minutes per utilization day (after implementation of PDPM). We urge CMS to continue monitoring the impact of the PDPM and its impact on beneficiaries that will allow CMS to quickly understand and address emerging problems affecting SNF residents.

In particular, AARP recommends that CMS develop specific measures to monitor and report regarding beneficiary impact. Among other measures, we believe this should include SNFs reporting the number of full-time equivalent rehabilitation therapy (physical therapy, occupational therapy, speech therapy) staff and the number of rehabilitation therapy hours per resident (patient) who has rehabilitation therapy ordered. CMS could also develop other outcome measures related to rehabilitation therapy for monitoring and reporting. This includes improvements in mobility and activities of daily living (ADLs) function, as well as percent of rehabilitation therapy residents (patients) discharged to the community. Given the importance of this issue, AARP recommends that CMS commission an outside contractor to examine the impact of the PDPM more fully on rehabilitation therapy and on beneficiaries.

**SNF Quality Reporting Program (QRP)**

**Influenza Vaccination Coverage among Healthcare Personnel (NQF #0431)**

AARP supports the proposed addition of the Influenza Vaccination Coverage among Healthcare Personnel measure (HCP Influenza) to the SNF QRP measure set to track the percentage of HCP within each SNF who receive the vaccine. The bulk of influenza-related hospitalizations and deaths occur among patients aged 65 years and older. SNF residents represent a subpopulation of older patients that is highly susceptible to this and other infectious diseases to which they may be exposed by SNF HCP, who often rotate between multiple facilities. This measure would provide insight into whether a facility is taking steps to limit the spread of influenza among its staff and residents and reduce the risk of within-facility transmission.

The measure is endorsed by the National Quality Forum and is currently included by CMS in other post-acute care (PAC) quality programs. AARP agrees with CMS that this measure could be publicly reported on Care Compare once technically feasible, but we note this measure has the same issue as the existing resident influenza and pneumococcal vaccination measures that we identify below in our comments on guiding principles for reporting disparity measures. Thus, those comments are also relevant in this case.

**Revised Compliance Dates for Transfer of Health Measures and Standardized Patient Assessment Data Elements**

CMS proposes to begin required data collection for two Transfer of Health (TOH) Information measures with FY 2024, after delaying it due to the COVID-19 Public Health Emergency (PHE). These measures track the transfer of vital information (i.e., current, reconciled, medication lists) during SNF resident transitions between transferring and receiving providers. AARP supports prompt implementation of these measures rather than further delay.

CMS similarly proposes to implement data collection starting in FY 2024 for the Impairment and Social Determinants of Health (SDOH) categories of standardized patient assessment data elements (SPADEs) that are part of the SNF Minimum Data Set (MDS) resident assessment instrument. The
required SPADEs include vision, hearing, race and ethnicity, preferred language, need for interpreter services, health literacy, transportation, and social isolation. AARP previously supported the addition of the SDOH category of SPADEs and we strongly support prompt initiation of their collection rather than further delay. Collection of this information during required assessments of SNF residents will enhance holistic care, call attention to impairments to be mitigated or resolved, and facilitate clear communication between residents and providers. Further, such data collection could allow for examination of SNF performance stratified for factors associated with health care disparities, such as race and ethnicity. AARP also supports quality reporting by SNFs on all residents regardless of payer as part of advancing equity in quality measurement.

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

1. **Cross-Setting Function** – CMS is considering a functional measure for use across all PAC settings that would incorporate both the domains of self-care and mobility. Maintaining and/or improving beneficiary functional status is a foundational goal of PAC for beneficiaries and providers. Measures of functional status have value for provider performance improvement and for informed decision making by individuals and families. AARP supports continued work by CMS focused on self-care and mobility measures, and we offer several related observations and suggestions.

AARP believes that accuracy and reliability are essential attributes of all quality measures. We note concerns expressed by others about accuracy and reliability of current PAC functional status measures, given the inherent conflict of interest created when the same assessment data are used for measure performance calculations and for case-mix adjustment to establish payments to PAC providers. Particular care, therefore, must be given to functional status measure design to discourage upcoding and gaming. Consumer-reported outcome measures for self-help and mobility could mitigate such behaviors and we encourage CMS to explore their development. Further, because individuals and families place high value on optimal functional outcomes, we recommend that any new measure have beneficiary and family caregiver input (e.g., as members of or advisors to the Technical Expert Panel) and be designed in a way that facilitates easily understood public reporting of results on Care Compare. Finally, we suggest the use of beneficiary and family caregiver focus groups or similar testing of potential measures to provide valuable feedback before measures are finalized.

2. **Health Equity Measures.** CMS expresses interest in structural measures that assess an organization’s leadership in advancing health equity goals or assess progress towards achieving equity priorities. These and other efforts in this proposed rule seem consistent with the CMS Framework for Health Equity 2022-2032. AARP applauds the ongoing efforts being made by CMS to embed equity and address health outcomes disparities through the agency’s many quality programs. Carefully constructed structural measures could provide important and actionable insights to facilities about the extent to which health equity has been incorporated into their organizational cultures. We support the exploration by CMS of structural measures of equity that are relevant and applicable to SNFs.

AARP also urges consideration of two additional measure concepts and a SPADE for adoption into the SNF QRP to assess progress by facilities towards achieving equity goals.

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a. *Facility Access Equity*. Disparities in SNF admissions screening decisions could embed inequity into a facility’s environment and culture, a downstream consequence of which would be implicit perpetuation of outcome disparities. Relevant measures could take the form of a simple ratio (SNF admissions divided by SNF applications/referrals) with stratified reporting by race, ethnicity, or other demographic and social risk factors, such as written or spoken language.

b. *Nursing Facility Resident “Dumping”*. AARP urges CMS to develop a measure focused on nursing facility resident “dumping”, the practice of inappropriately or abruptly discharging or transferring a resident when a facility no longer wants to meet the resident’s needs. For example, the Superior Court of California ruled last year that a facility violated a resident’s rights and the law by refusing to readmit her after she was temporarily hospitalized.17 AARP Foundation attorneys are co-counsel in this case. We are hearing about the occurrence of such resident dumping with increasing frequency, particularly involving residents with dementia.

We understand that facility-initiated transfers and discharges remain the leading topic among complaints to long-term care ombudsman programs across the country. 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, the extent of dumping behaviors and patterns of occurrence related to resident characteristics (e.g., dementia diagnoses) and facility attributes (e.g., Medicaid-dependent), and above-average interfacility transfer rates.

c. *SPADE for Caregiver Status*. AARP strongly supports the addition of Caregiver Status to the list of standardized patient assessment data elements required for reporting by SNFs and other PAC providers. This data point would identify whether the beneficiary has a family caregiver (who may or may not be the next of kin) and identify that individual to the facility, including contact information (with consent of the resident and the family caregiver). Family caregivers (defined broadly) are important sources of information about individual preferences, can contribute observations about SNF resident status that are not readily apparent to facility staff, and provide essential psychosocial support. Involving the caregiver during the discharge planning process can help the beneficiary make a smooth transition home or to the next provider setting. Absence of an identifiable caregiver also may serve as a marker for other social risk factors that influence individual outcomes (e.g., social isolation) and could be a valuable element for use in stratified performance reports for facilities. It also provides an opportunity to identify and provide needed support for a family caregiver, such as education and training, especially around care transitions. AARP encourages CMS to consider adding SPADEs for education level and income.

3. *COVID-19 Vaccination Coverage among PAC Patients*. CMS is seeking input on the value of a measure assessing whether SNF patients are current on their COVID-19 vaccinations. AARP believes such a measure would be a relevant and valuable addition to the SNF QRP measure set, though it seems it should be coordinated with existing measures of resident COVID-19 vaccination and booster rates to avoid confusion or duplication. COVID-19 vaccinations and boosters are an important part of preventing the horrific number of deaths we have seen among nursing home and other long-term care facility residents and staff during the pandemic.

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Verified vaccination status for both staff and residents should be key elements of each facility’s infection control and prevention plan. Measure specifications will need to address the inclusion of booster doses. Strong consideration should be given to providing results to facilities that are stratified for race, ethnicity, and other social risk factors. Selected results also should be publicly reported on Care Compare, while protecting resident privacy, to aid beneficiaries and families in selecting a facility. However, CMS should consider how this may modify current nursing home resident COVID-19 vaccination and booster rates on Care Compare and prevent confusion by avoiding reporting of multiple similar measures on this. Any posted information must be provided in language easily understood and correctly interpreted by residents, consumers, and their family caregivers. See also our comments on vaccination measures below under guiding principles for reporting disparity measures.

**Request for Information (RFI): Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs**

**General Considerations**

AARP applauds the ongoing efforts being made by CMS to close Medicare’s equity gap through initiatives across its quality program portfolio. We firmly believe that ensuring health care equity promotes better quality of care for all older Americans. We remain committed to working with CMS and other stakeholders to ensure all our nation’s seniors who seek care in Medicare-certified skilled nursing facilities can achieve optimal and equitable health outcomes. The risks and tragic consequences for this beneficiary population when SNF care is suboptimal and outcomes are disparate were never more evident than immediately after the onset of the COVID-19 Public Health Emergency (PHE). A recent systematic assessment of the current state of our nation’s nursing homes from the NASEM also speaks to the challenges that continue to be faced by SNFs and their residents. AARP supports, and recommends for serious consideration by CMS, Recommendation 6D from the Academies’ report that addresses health equity in these facilities; we are pleased to note that several elements of this recommendation already are under discussion via this RFI (e.g., development of new measures of disparities). Finally, we note that while our comments today focus on the SNF QRP, many of our concerns and suggestions also are applicable to nursing homes caring for long-term residents.

**Cross-Setting Framework to Assess Healthcare Quality Disparities**

**Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across CMS Quality Reporting Programs**

CMS is considering making tools available to health care providers that will facilitate identification of disparities in the care they deliver, and support development of data-driven interventions tailored to their practices. AARP appreciates the potential value of stratified results reporting to SNFs to accelerate progress by facilities in recognizing and closing their equity gaps. We recommend that CMS

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consider making reports available to state surveyors to assist them in observing whether facilities are in fact taking actions to address identified disparities.

**Guiding Principles for Selecting and Prioritizing Measures for Disparity Reporting**

AARP strongly recommends as a guiding principle that only measures for which data elements are clearly defined, valid, and well standardized be prioritized. We also recommend to your review the set of principles we developed for race and ethnicity metrics based upon our experiences with stratified tracking of state-level COVID-19 metrics.\(^{21}\) We strongly encourage CMS to give high priority to measures developed in response to issues identified through review and analysis of resident and family complaints, Quality Improvement Organization (QIO) outreach, ombudsman investigations, and surveyor reports. If a resident experience-of-care measure is adopted into the SNF QRP, that measure should also be given high priority. If such a measure is considered, we recommend the Nursing Home Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

**Principles for Social Risk Factor (SRF) and Demographic Data Selection and Use**

CMS states the value of considering a wide range of demographic and social risk variables for use in disparities analyses (e.g., race, ethnicity, nutrition, and housing availability). Conversely, CMS also states the challenge posed by the plethora of variables for which associations with disparities have been suggested. Practical limitations to the number of variables to be studied also must be considered. AARP concurs with CMS that initial consideration must be given to a wide range of variables but also recognizes that the field must promptly be narrowed. We strongly recommend that variables to be examined be required to have clear, standardized definitions and be meaningful to beneficiaries as determined through a formal and transparent process for obtaining their input. Variables chosen for initial investigation should have robust, established data sources. However, CMS should consider how to capture LGBTQ+ status (sexual orientation and gender identity) among Medicare and Medicaid beneficiaries, for which correlations with care disparities are well-documented but limited person-level data are available across current CMS reporting systems and for which suitable proxy variables are lacking. As a result of work in this area, CMS should ensure in further rulemaking or other administrative action that it receives these data and can use them to measure disparities and take action.

CMS acknowledges that patient-reported data are considered the gold standard but may have limited availability. When such data are absent, CMS is considering using substitutes such as administrative data (e.g., claims, enrollment), area-based indicators (e.g., Area Deprivation Index), and imputed data (e.g., predicting race/ethnicity from administrative data). AARP recognizes the barriers to disparity analyses created by the paucity of certain self-reported data. We note a community effect has been demonstrated for SNFs, such that a facility located in a resource-poor community or one that has been underinvested in is more likely to struggle with quality measures and fiscal sustainability.\(^{22}\) This community effect can span across relevant domains for a facility—fewer workers who can access the facility or want to work there, fewer transportation and housing options for workers, and more.

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CMS endeavors to better measure equity across settings it funds, the agency should consider how the community a facility is in could impact its operations.

Guiding Principles for Reporting Disparity Measures

Outside of mandatory reporting, CMS believes that both overall and stratified results routinely should be reported together, and AARP concurs since overall improvement without disparities reduction is a hollow victory and could reflect system gaming by providers. AARP agrees that initial provider-only reporting can help detect unintended consequences or confusing results before new data are publicly reported, but we recommend that a clear plan for transitioning to public reporting always accompany initial private reporting. Finally, AARP concurs with CMS that public reporting of disparities comparison results must be sensitive to the risks of further disadvantaging providers who serve populations and areas with limited resources (e.g., SNFs located in low-income, under-resourced, and rural communities). This sensitivity, however, should not take the onus off such providers from taking necessary corrective action.

AARP strongly recommends that ease of data access be an additional guiding principle when making disparities reporting decisions. For example, researchers and other consumers currently experience great difficulty in obtaining demographic data across Medicare settings that link to outcomes, specific quality measures and more, and the linked data available is nearly impossible to navigate. CMS should take steps to make more of these data publicly available and easy to find, including through the Care Compare platform. We also further suggest inclusion of overlaid data for people to better understand care experiences across individual demographic traits (e.g., Black women, Hispanic individuals from rural areas) in what is made more available.

AARP notes potential issues with current data collection and publication practices that may mask persisting disparities among SNF residents and unintentionally mislead consumers. In Care Compare, rates of SNF resident influenza and pneumococcal vaccination count both vaccinated residents and unvaccinated residents who were approached for the vaccine, but denied it as vaccinated, producing higher vaccination rates. Inclusion of vaccine denials is counter to the name and description of the measure, which is measuring who received a vaccination. Further, the current measure may mask persisting disparities by race/ethnicity. The way residents are approached and/or respond to approaches for vaccination may vary by race/ethnicity and including those who “deny” a vaccine in this measure could hide disparities of actual vaccine receipt. It is also helpful to have consistency across similar measures. COVID-19 vaccination measure rates posted on Care Compare do not count denials as vaccinations. We encourage CMS to update influenza and pneumococcal immunization reporting to parallel that of COVID-19 vaccination rates.

Our comments note the importance of data collection and reporting broadly. However, it is also critical that the data is analyzed and acted on, so that issues are identified, and actions taken to solve known inequities.
Approaches to Assessing Drivers of Healthcare Quality Disparities and Developing Measures of Healthcare Equity in the SNF QRP

Alternative Methods to Identify Disparities and the Drivers of Disparities

Regardless of methods chosen to identify disparities and their drivers, AARP strongly recommends that CMS incorporate qualitative inputs already available to the agency. These could include surveyor observations, resident and family caregiver complaints, ombudsman reports, and insights gleaned during QIO interactions with facilities. We encourage CMS to establish a mechanism for regular and consistent data mining of these qualitative inputs as a part of the agency’s strategic plan for achieving health equity. Surveyor training about disparity identification could enhance the value of the observations made during site visits or surveys. For example, we understand that reporting of pressure ulcers and other adverse outcomes by some facilities for certain racial groups may be purposefully incomplete. Trained surveyors presumably would more readily detect such provider behaviors. There is a need for education and training to understand and identify biases, help identify where there may be issues with data reporting, and create measures to address these issues. It is also important to address the diversification of surveyors in efforts to recruit and retain surveyors, who do the critical work of inspecting nursing homes and ensuring appropriate oversight, enforcement, and accountability.

CMS should emphasize and pay attention to the incentivization of collecting data so that it is done ethically and intentionally for researchers, providers, and consumers to truly understand and address disparities. For example, regarding pressure ulcers where racial/ethnic differences historically exist, there is evidence showing that some facilities are not reporting the true count of pressure ulcers and other poor quality of care data among certain racial groups (e.g., African American/Blacks, Hispanics/Latinos) because these providers/organizations are afraid to report information for which they do not want to be held responsible. Therefore, CMS should consider these issues, and implement parameters and strategies around oversight. Efforts should be undertaken to ensure providers do not game the system and that there is a level playing field.

Measures Related to Health Equity (SNF QRP)

Degree of Hospital Leadership Engagement in Health Equity Performance Data

CMS describes the Hospital Commitment to Health Equity (HCHE) measure recently proposed for adoption into the Hospital Inpatient Quality Reporting Program included in the FY 2023 inpatient hospital payment system proposed rule and asks whether this measure could be adapted for the SNF QRP. The HCHE measure is a structural measure in which a facility attests to each of five domains of organizational commitment to health equity: strategic plan, SDOH data collection; disparities analysis; quality improvement activities; and leadership involvement.

AARP believes that the HCHE measure proposed for inpatient hospitals could be a strong complement to SNF quality reporting and provide deeper insights into organizational health equity commitment than currently available related to organizational commitment to equity in SNFs. We support the creation of a similar measure for the SNF QRP and we stand ready to support CMS in the development of future measures focused on nursing homes. We strongly encourage CMS to soon move beyond attestation as the sole component for HCHE measure scoring. This could take the form of a requirement for supporting documentation review during state survey visits. Finally, we strongly
recommend development and incorporation of equity-focused measures for long-stay nursing home residents into the Nursing Home Star Rating System.

**Request for Information (RFI): Inclusion of the CoreQ: Short Stay Discharge Measure in a Future SNF QRP Program Year**

CMS requests feedback on the inclusion of the *CoreQ: Short Stay Discharge* measure in the SNF QRP in future program years to assess the level of satisfaction among SNF residents. AARP has repeatedly voiced support for the addition of experience of care measures to the SNF and other PAC settings. We continue to firmly believe that this type of measure is important, relevant, and applicable to SNFs. However, we also continue to firmly believe that the CAHPS Nursing Home Discharged Resident survey is clearly superior to the CoreQ Short Stay Discharge survey for this purpose. The CAHPS survey is the product of a rigorous development process co-sponsored by CMS that included literature review, resident and family focus groups, user group testing for comprehensibility, and field testing for reliability and validity. Specific, actionable aspects of resident experience are queried (e.g., response time of facility staff to calls for help). In comparison, the CoreQ survey consists primarily of summative satisfaction ratings (e.g., overall rating of care) rather than actionable queries and only one of 5 response choices is negative. CoreQ survey development included input from an industry workgroup. In the FY 2022 SNF PPS final rule, CMS reported that commenters found CoreQ questions too vague and the overall survey to be too limited to sufficiently capture patient experience for quality measurement. AARP also notes the recent recommendation by the National Academies for adoption of the CAHPS survey in its 2022 report on nursing home quality.

**Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program**

**Quality Measure Proposals for the SNF VBP Expansion Beginning with the FY 2026 Program Year**

The Consolidated Appropriations Act of 2021 (CAA) amended section 1888(h) of the Social Security Act, and allows for the addition of up to 9 new measures to the SNF VBP Program, including but not limited to measures of patient safety, care coordination, patient experience, functional status, skin integrity, medication reconciliation, and major falls. The SNF 30-Day All-Cause Readmission Measure (SNFRM) as currently specified remains in the measure set. CMS proposes to add two new measures to the Program’s measure set beginning with the FY 2026 program year and one new measure for the FY 2027 program year. CMS believes that delaying new measure adoption until program year FY 2026 will facilitate SNFs gaining familiarity with the new measures and with other programmatic changes needed to implement the expanded measure set.

a. **SNF Healthcare-Associated Infections Requiring Hospitalization (SNF HAI)**

CMS proposes to add this claims-based, patient safety outcome measure to the SNF VBP program’s measure set beginning with program year FY 2026 to estimate the risk-standardized rate of HAI.

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acquired during SNF care that result in hospitalizations. CMS plans to seek NQF endorsement of the measure but does not identify a time certain for doing so.

AARP strongly supported the addition of this measure to the SNF QRP during FY 2022 rulemaking and we likewise support its addition to the SNF VBP. As was tragically demonstrated during the early stages of the COVID-19 PHE, 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. The measure is well-suited for the value-based purchasing program because it offers a clear opportunity to align payment with performance on a quality measure that is of high importance to residents and family caregivers. 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 through stratified results reporting to facilities. Public reporting should follow promptly thereafter, once any operational issues with or unintended consequences of measure implementation are resolved. Finally, we urge CMS to proceed promptly with seeking NQF endorsement for this measure.

b. Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing)

CMS proposes to add this structural measure to the SNF VBP program’s measure set beginning with program year FY 2026. The measure is based on a similarly titled measure included in the Nursing Home Five-Star Quality Rating System. Total nurse staff hours for a facility, from the CMS Payroll-Based Journal (PBJ) system, are divided by the number of SNF residents in the facility per day, which is calculated by CMS from each facility’s Minimum Data Set (MDS) assessments. Staff hours are case-mix adjusted based on resident classifications into Resource Utilization Groups (RUG-IV). Nursing hours included in this measure are those logged into the PBJ for staff types: RN (Registered Nurse), LPN/LVN (License Practical or Vocational Nurse), and NA (Certified Nursing Assistant, aides in training, medication aides and techs). Hours for RN and LPN/LVN staff types who have administrative duties are included in the measure. Staff are further categorized as facility employees or working under contract. “Private duty” staff employed by residents/families are not included.

With a caveat below, AARP is very supportive of a total nurse staffing measure and other potential measures, such as staff turnover rates, that consistently assess SNF nurse staffing patterns. The importance of data accuracy for this measure cannot be overstated but should be ensured using PBJ data, which can be audited and verified. Numerous studies have previously identified correlations between nurse staffing and multiple patient outcomes, and associations are especially strong for benefits from increased RN staffing (e.g., fewer pressure ulcers, less restraint use, reduced risk of hospitalization). More recently, links between SNF nurse staffing and adverse outcomes during the COVID-19-PHE have been demonstrated. The improved outcomes for which correlations have been reported are well-aligned with resident and family priorities, making the proposed measure particularly suitable for inclusion as a metric of value-based purchasing.

AARP is very concerned, however, about the inclusion of data for the staff types of RN with administrative duties and LPN/LVN with administrative duties. Counting hours that are not invested in direct resident care is contrary to the spirit of the total nurse staff measure and reduces the meaningfulness of the measure to current residents and families and to those making choices about impending SNF admissions. Just as with the establishment of federal minimum nursing staffing requirements, a measure of total nursing staffing should only count time that RNs, LPNs/LVNs, and CNAs spend providing direct resident care. We urge CMS to ensure this in any SNF VBP total nurse staff measure. We also express concern about including medication aides or technicians and aides in training in a total nurse staffing measure, as they are not RNs, LPNs/LVNs, or CNAs. We also noted similar concerns in the development of federal minimum nursing staff standards.

 Appropriately, staffing hours provided by nurses who are employed by residents and families (“private duty”) are not included. However, we also observe that the presence of such private duty nursing staff could signal insufficient facility-paid staffing to meet residents’ needs. It may be helpful to know how much private duty nursing is used in facilities, but it should not be included in the measure of total nursing hours per resident day. Additionally, we encourage CMS to proceed expeditiously with obtaining NQF endorsement of this measure. Finally, we support complete and transparent reporting of this measure’s results on Care Compare in a manner that is easily understood by consumers.

c. Discharge to Community – Post-Acute Care Measure for SNFs (DTC-PAC-SNF) (NQF #3481)

CMS proposes to add this claims-based care coordination and outcome measure to the SNF VBP Program’s measure set beginning with program year FY 2027. The measure is currently part of the SNF QRP measure set and uses Medicare Fee-for-Service (FFS) claims data to determine the rate of successful discharge to the community from the SNF setting. Besides being an outcome generally desired by SNF residents, beneficiary discharge to the community often results in lower costs to Medicare. CMS also believes the DTC-PAC-SNF measure to be actionable for SNFs, as interventions targeted toward increasing DTC rates have shown some success (e.g., more comprehensive discharge planning).

AARP supported the addition of the Discharge to Community measure to the SNF QRP and we likewise support its adoption into the SNF VBP’s expanded measure set. The outcome, successful discharge from SNF care, aligns closely with the priorities of beneficiaries and their families, as most older adults want to live independently in their homes and communities, and it is well-suited for use as a value-based purchasing metric. However, we do urge CMS to modify the measure so that post-discharge emergency room (ER) and hospital observation visits within 31 days are also tracked, not just hospitalizations or admission to other institutional PAC sites. Early or multiple ER visits post-SNF discharge could be a proxy for premature discharge or incomplete discharge planning. We believe ER visits could be readily identified using the same sources that CMS will already be using for other elements of this measure. We support the public reporting of this measure on Care Compare.

Request for Comment on Additional SNF VBP Program Measure Considerations for Future Years

a. Staffing Turnover Measure

CMS seeks comment on its plan to propose adding a nurse staffing turnover measure to the SNF VBP Program measure set during FY 2024 rulemaking. The primary data source would be the PBJ system.
The measure’s design would be based on the staff turnover measure currently in use by the Nursing Home Five-Star Quality Rating System, in which the percent of total nurse staff that have left a facility over the last year is calculated. Total nurse staff is defined to include RNs, LPNs/LVNs, and nurse aides (CNAs, aides-in-training, and medication aides/technicians) and to include both facility employees and contract staff. In January 2022, CMS began posting nursing home turnover information on Care Compare, posting the percentage of nursing staff and number of administrators that stopped working at the nursing home over a 12-month period. Turnover rates for both total nurse staff and RN staff are provided. Starting in July 2022, turnover rates will be incorporated into Staffing Domain scoring and thereby contribute to facility star ratings.27

AARP strongly supports nurse staff turnover as a wholly appropriate and high impact quality measure concept for the SNF VBP Program. Inconsistent staffing due to high turnover can be disruptive to the health, safety, and well-being of residents, particularly for those with dementia. High turnover and low staff retention rates may indicate poor treatment of employees by a facility. Low nursing and administrator turnover rates have been linked to improved resident outcomes and fewer citations for health and safety deficiencies.28

AARP views the total nurse staff turnover measure currently in use by the Nursing Home Five-Star Quality Rating System (public reporting starting in July) as a good starting point for a SNF VBP nurse staff turnover measure. We believe that the transparent and auditable PBJ staff reporting system should allow for comprehensive and accurate turnover data collection. However, we do recommend consideration of several modifications. Nurse turnover rates should be calculated and publicly reported both as total nurse staff that turned over and RN staff that turned over. Only nurses providing direct care to residents should be included in measure calculations, not those with administrative duties. Consumers will intuitively assume that nurse staffing measure results are for nurses devoted to resident care rather than to administrative responsibilities. If CMS includes nursing staff with both direct care and administrative responsibilities in a staffing turnover measure, CMS should explore how many nurse hours of direct resident care per day as compared to nurse hours spent on administrative work were turned over in both total nurse staff and RN staff.

Turnover can be voluntary or involuntary and the Five-Star Rating system measure does not distinguish between them. Involuntary turnover presumably represents termination of staff who are not meeting performance expectations, although a single facility’s involuntary turnover rate should not greatly exceed that for peer facilities in its region. Concerns about a facility’s financial situation could also impact turnover. Drilling down to assess involuntary turnover might be reserved for facilities that have higher-than-expected turnover rates rather than done for all facilities. Adjustment may be needed for certain facility characteristics, as facility size and ownership have been correlated with staff turnover and retention. For facilities under chain ownership, individual facility rates rather than a chain overall average rate should be calculated and publicly reported. Ownership data sufficient to allow researchers and policy makers to examine chain performance should be made publicly available. CMS should also consider innovative care models, such as small house nursing homes, in the context of the staff turnover measure.


AARP recommends that the total nurse staffing and staff turnover measures not be combined into a composite measure. We believe that consumers, their family caregivers, researchers, and policymakers are best served by separate reporting of these and other staffing measures. These are important pieces of information for consumers and their families selecting a facility and consumer should have access to data on both measures. We note the presence of total nursing staff turnover and RN turnover on Care Compare already. Separate determination and reporting of staff turnover would allow for stratified reporting based on facility, staff member, and resident characteristics and provide insights into potential disparities.

b. CDC-National Health Safety Network (NHSN) COVID-19 Vaccination among Health Care Personnel Measure (HCP COVID-19 Vaccination Measure)

CMS requests feedback about the future addition of the HCP COVID-19 Vaccination Measure to the SNF VBP measure set. Adoption of this measure into the SNF QRP was finalized during FY 2022 and the measure’s facility-level results are to be reported on Care Compare. The measure tracks the percentage of HCP within each SNF who receive a complete COVID-19 vaccination course.

AARP strongly supported the addition of this measure to the SNF QRP and we likewise firmly support its addition to the SNF VBP. The measure addresses a topic area that is of high importance to beneficiaries and families, and—as is appropriate for a value-based measure—it would link payment to an actionable SNF resident safety intervention. The devastating and disproportionately high impacts of COVID-19 on nursing home residents and staff have been well-documented, and accountability for this measure through payment adjustments should encourage all SNFs to maximize staff vaccination, leading to reduced COVID-19 infection rates among staff and residents and decreased mortality and morbidity rates for all. Finally, AARP agrees with CMS that this measure is appropriate to publicly report on Care Compare as soon as technically feasible, and we note the existing nursing home resident and staff COVID-19 vaccination and booster rates on Care Compare. Coordination is needed to ensure the best and most useful information for consumers. We also urge that reported data include demographic information while protecting individual privacy to highlight potential disparities similar to those already uncovered about COVID-19 variation within facilities and among staff and residents. CMS should also consider updates to this measure, such as boosters, and possible future adjustments as COVID-19 continues to evolve.

Request for Comment on Validation of SNF VBP Program Measures and Assessment Data

CAA, 2021 also requires the development and implementation of a validation process for SNF VBP Program measures and data. As a first step, CMS proposes to continue the current work done by the Medicare Administrative Contractors (MACs) to ensure SNF VBP incentive payment accuracy (e.g., reviews of medical necessity, pre- and post-payment audits) done for the Program’s current single measure (SNFRM) and to codify that work in regulation (at §413.337). For subsequent years and the expanded SNF VBP measure set, CMS requests input about additional validation methods that would be appropriate and applicable to the Program’s new measures as well as to the quality measure data and MDS assessment data that are submitted by facilities.

AARP supports the value of and absolute necessity for a validation process tailored to the expanded SNF VBP Program. This is especially critical as the SNF VBP Program provides clear financial incentives for better performances by facilities (achievement and improvement). The Hospital Value-Based Purchasing (HVBP) Program and its validation process may provide some insights for the SNF
VBP validation process, allowing for differences between the two programs. While AARP believes that sooner is better for the start of SNF VBP Program validation, we agree with the suggestion from CMS that the FY 2026 program year is likely to be the earliest feasible timeline since the SNF VBP Program measure set will not include more than one measure until that program year. We strongly recommend that beneficiary and family caregiver representatives be consulted during validation process development so that the process results ultimately can be reported publicly in a manner that is meaningful for them. In general, CMS should also monitor the SNF VBP for any unintentional consequences of its expansion and address them accordingly.

Request for Comment on a SNF VBP Program Approach to Measuring and Improving Health Equity

CMS notes the many operational changes that are being proposed elsewhere in this rule for the SNF VBP Program. The changes are designed to facilitate implementation of the Program’s expanded measure set. CMS requests comments focused on policy options in support of health equity that could be incorporated into the Program alongside the proposed operational modifications. AARP commends CMS for seeking to embed health equity considerations into the Program concurrently with the proposed process changes.

CMS asks whether equity-related adjustments should be incorporated into the SNF VBP Program to reflect the varied patient population that SNFs serve nationwide. AARP agrees that any adjustments adopted must be meaningful and applicable across the SNF beneficiary population. However, we note that because shorter-stay SNF residents are often cared for in facilities that also serve long-stay residents, efforts must be made to ensure that SNF VBP Program adjustments first are meaningful and appropriate for the shorter-stay subpopulation. Separate pathways exist for making equity-based interventions for long-stay facilities and their residents and ensuring equity for both types of residents is critical. At the same time, CMS should be aware of and appropriately consider any impacts on long-stay residents and avoid unintended consequences.

CMS next asks if payment adjustments to SNFs under the Program should be tied to health equity outcomes. AARP observes that the foundational intent of value-based purchasing programs such as the SNF VBP is to link payment to desired outcomes, including equitable health care delivery. Prioritizing outcomes to be addressed and designing payment policies that are effective without creating new disparities or unintended consequences will be essential requirements for an effective health equity strategy for the Program. Further, equity policies for the SNF VBP Program should be harmonious with and complementary to those of the SNF QRP and to Medicare’s Conditions of Participation.

Finally, AARP wants to note two broader issues. First, given the importance of transparency and timely information, we encourage CMS to post nursing home survey data on Care Compare as soon as possible to provide individuals and their families the most current picture possible of facility survey results. Secondly, as part of President Biden’s nursing home reforms, he proposed providing technical assistance to nursing homes to help them improve. We encourage the Administration to target such technical assistance to areas with unique needs or challenges, such as providing care in frontier, remote, or rural areas.
CONCLUSION

AARP appreciates the opportunity to comment on this proposed rule. We urge CMS to keep the needs of residents and their families front and center as you finalize this rule and make longer-term policy decisions, including establishing mandatory federal minimum staffing levels for nursing homes. 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