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Advancing Health in America

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Submitted electronically

Re: 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:

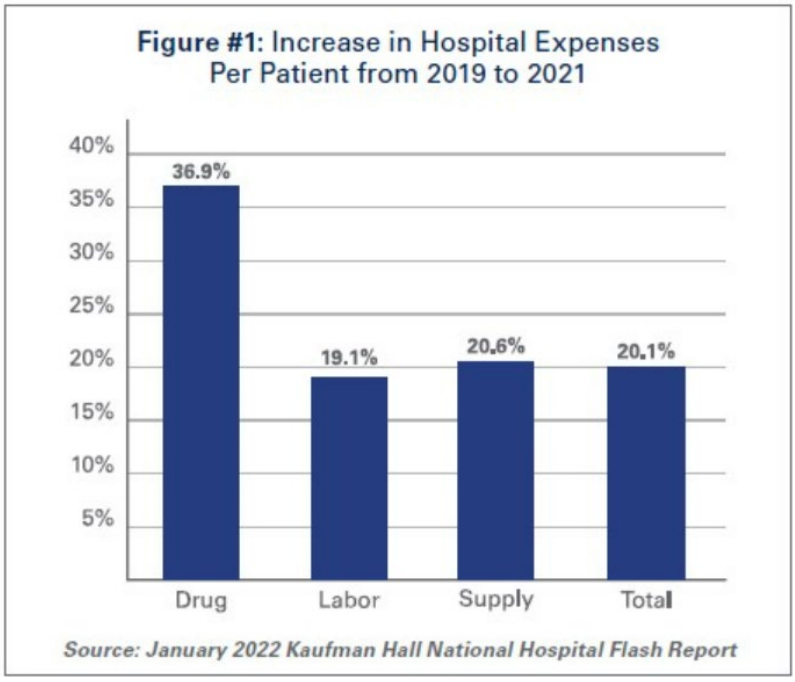
On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 700 skilled-nursing facilities (SNF), and our clinician partners — more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to address the FY 2023 SNF prospective payment system (PPS) proposed rule.

Proposed FY 2023 Payment Update Warrants Closer Examination
For FY 2023, CMS is proposing a net *decrease* in SNF PPS payments of 0.9% ($320 million), relative to FY 2022, which includes a 2.8% market-basket update, the statutorily-mandated cut of 0.4 percentage points for productivity, a significant cut related to the FY 2020 implementation of the current case-mix system, and other provisions. Among these changes, we note that the proposed SNF PPS labor-related share would only modestly shift upward from 70.4% in FY 2022 to 70.7% in FY 2023, relative the current cost pressures on the field, as discussed below.

The timing of this proposed net decrease in payments could not be worse, given the well-documented impact of the COVID-19 public emergency (PHE) on the SNF and nursing home field. In many ways, hospital-based (HB) SNFs experienced the PHE differently than their freestanding counterparts because of linkages to their host hospitals. This enabled them to have more robust infection controls, easier access to

personal protective equipment and other factors that affected their overall PHE response. That said, HB SNFs and their host hospitals also faced immense challenges with each surge of the pandemic and its after-effects, including supply chain, workforce and over-crowding crises. **As such, our HB SNF members are in full agreement with the broader hospital field over the inappropriateness of reducing payments to this critically important part of the continuum of care during a PHE. Rather than reduce payments, we urge CMS to continue to provide financial support needed to support the ongoing PHE response, as well as the early efforts being made to support post-PHE recovery.**

We have specific concerns with the magnitude, methodology and timing of CMS's proposed parity adjustment, which are described in greater detail below. The proposed payment update is woefully inadequate given feedback from our hospital and hospital-based SNF members and the findings of recent AHA-commissioned research finding significant cost growth in hospitals. Specifically, an April 2022 report by the AHA highlights the significant growth in hospital expenses for labor, drugs and supplies (as shown in the reproduced chart below), as well as the impact that rising inflation is having on hospital prices.



The report cites Bureau of Labor Statistics data showing that hospital employment levels have decreased by approximately 100,000 from pre-pandemic levels. At the same time, hospital labor expenses per patient through 2021 were 19.1% higher than pre-pandemic levels in 2019. Because labor costs account for more than 50% of hospitals' total expenses, such increases have very substantial impacts on a hospital's total expenses

and operating margins. As a result of these changes, January 2022 labor expenses per adjusted discharge are 52% higher than the pre-pandemic levels of January 2020. These trends also pertain to HB SNFs, which both use higher levels of registered and other nurses, relative to freestanding SNFs and face the same environmental pressures as their host hospitals. In addition, these trends indirectly affect the recruitment and retention challenges faced by non-hospital healthcare employers in the area, and track with the experience of freestanding nursing homes and SNFs.

While the AHA supports the proposed forecast error correction of 1.5 percentage points, we are deeply concerned that the overall net decrease in SNF payments does not reflect the increased costs hospitals, their HB SNFs and other distinct part units are facing. We urge CMS to discuss in the final rule how the agency will account for these increased costs.

We also are concerned about the proposed 0.4% reduction for productivity and ask CMS in the final rule to further elaborate on the specific productivity gains that are the basis for this proposed market basket offset, as it contradicts our members' PHE experiences of actual *losses* in productivity during the pandemic.

Proposed Parity Adjustment for the FY 2020 Implementation of the Patient-driven Payment Methodology (PDPM)

The AHA strongly opposes CMS's proposed 4.6% parity adjustment, which the agency states is necessary to help ensure the budget-neutral implementation of the PDPM case-mix system, which took effect in FY 2020. The agency estimates the impact of the adjustment would be a cut of approximately $1.7 billion in FY 2023 alone, an overwhelming amount to a provider community still struggling to provide access to care during a PHE. Further, the agency is proposing that the parity adjustment equally apply to all SNFs and all components of the PDPM case-mix system, and be implemented with no delay or phase-in period. **Simply put, the SNF field is not equipped to bear the weight of a 4.6% cut given the impact of the PHE combined with the inflationary and other cost increases it is enduring, as described above. The proposal is particularly ill-timed given that CMS is not statutorily required to implement a cut for FY 2023.**

In addition, the AHA has a longstanding policy of urging the agency to phase in substantial fluctuations in payment rates in order to promote predictable and reliable payments for the field. **As such, if the agency does implement the parity adjustment in the future, we urge it to consider phasing it in, particularly given its current magnitude and likely overwhelming impact on the field.**

Proposed Permanent Cap on Wage Index Decreases
In order to mitigate fluctuations in year-to-year wage index changes, CMS proposes a permanent 5.0% cap on any decrease to a provider's wage index, relative to the prior

year, regardless of the circumstances causing the decline. We agree that such a cap would help maintain stability for this payment system, and the others for which CMS also is proposing this cap. **As such, while we support this proposed policy, we urge the agency to implement the change in a non-budget-neutral manner. Only then would the proposed cap truly help stabilize hospital finances.**

QUALITY REPORTING-RELATED PROPOSALS

SNF Quality Reporting Program (SNF QRP)

The Affordable Care Act mandated that reporting of quality measures for SNFs begin no later than FY 2014. Failure to comply with SNF QRP requirements will result in a 2.0 percentage point reduction to the SNF's annual market-basket update. For FY 2023, CMS requires the reporting of 13 quality measures by SNFs.

CMS proposes to add one new measure to the FY 2025 SNF QRP. In addition, CMS proposes to revise the compliance date for previously adopted measures and standardized patient assessment data elements (SPADEs) whose implementation was delayed due to the COVID-19 public health emergency (PHE). Finally, CMS seeks feedback on several requests for information (RFIs).

Adoption of Influenza Vaccination among Health Care Personnel (HCP) Measure. CMS proposes to adopt this CDC-developed measure, beginning with the FY 2025 SNF QRP. The measure assesses the percentage of HCP who receive an influenza vaccination any time from when it first became available through March 31 of the following year. If finalized, SNFs would be required to enter a single summary report into the National Healthcare Safety Network (NHSN)'s module at the end of each annual measure reporting period, beginning with the Oct. 1, 2022-March 31, 2023 flu season. Performance on this measure would be publicly reported, beginning with the October 2023 Care Compare refresh, or as soon as technically feasible.

The AHA supports the adoption of this measure for the SNF QRP. The measure is endorsed by the National Quality Forum (NQF) and has been used in CMS quality reporting programs in the past, demonstrating its feasibility. Vaccination among health care personnel serving SNF residents is important considering the vulnerable state of SNF residents as well as the high rate of viral transmission in residential facilities. The topic is valuable to patients and the community and the measure steward has demonstrated variation in performance on this measure across the country, so use of this measure is likely to result in improved rates of vaccination. In addition, several thousand nursing homes have voluntarily reported weekly influenza vaccination coverage through NHSN during the 2020-2021 influenza season.

Due to the similarities in subject matter between this measure and the COVID-19 Vaccination among HCP measure adopted in last year's SNF PPS final rule, we encourage CMS to consider how to align definitions and reporting requirements across

those two measures so as to reduce confusion and burden. For the influenza vaccination measure, SNFs record the numerator in five categories:

1. HCP who received a vaccination at the facility;
2. HCP who reported in writing or provided documentation that they received a vaccination elsewhere;
3. HCP who were determined to have a medical contraindication, including severe allergic reaction to eggs or other components of the vaccine, or a history of Guillain-Barre syndrome within six weeks after a previous influenza vaccination;
4. HCP who were offered but declined the vaccination; and
5. HCP with unknown vaccination status

For the COVID-19 vaccination measure, however, the numerator is recorded in ten categories (and five additional categories for booster doses):

1. HCP who received only dose 1 of the Pfizer-BioNTech vaccine;
2. HCP who received both doses of the Pfizer-BioNTech vaccine;
3. HCP who received only dose 1 of the Moderna vaccine;
4. HCP who received both doses of the Moderna vaccine;
5. HCP who received the single-dose Janssen vaccine;
6. HCP who received a complete vaccination series, manufacturer unspecified;
7. HCP who received any completed vaccine series;
8. HCP with medical contraindication to the vaccine;
9. HCP who were offered but declined the vaccine;
10. HCP with unknown vaccination status.

We understand the reasons for some of the nuances in the COVID-19 vaccination among HCP measure, but encourage CMS and CDC to consider whether the distinctions in manufacturers are necessary for reporting in the future. In addition, we note the discrepancies between the measures in recording whether the HCP received their vaccination at the facility or provided documentation that they received it elsewhere. There are differences between influenza and COVID-19 that are not (yet) able to be reconciled—such as defined seasonality—so any opportunity to simplify reporting and interpretation of the data related to these measures would improve their usability.

Revised Compliance Date for Previously Finalized Measures and SPADEs. CMS proposes to require SNFs to begin data collection on two previously finalized measures and several SPADEs, beginning Oct. 1, 2023. SNFs were originally scheduled to begin required data collection on the measures, Transfer of Health Information (TOH) to the Patient and Transfer of Health Information to the Provider, and certain SPADEs, beginning Oct. 1, 2020. In May 2020, CMS issued an interim final rule acknowledging the effects of the COVID-19 public health emergency (PHE) and extending the timeline

for these requirements until Oct. 1 of the year that is at least two full fiscal years after the end of the PHE.

In this proposed rule, CMS explains that the agency has offered SNFs significant flexibilities throughout the PHE by granting waivers of regulatory requirements, and has provided guidance and assistance to help SNFs during the pandemic. In addition, CMS believes that "providers may already be recording for their own purposes" data related to the previously finalized but delayed SPADEs, which address social determinants of health.

Considering that CMS finalized rules accelerating the timeline for required reporting for IRFs and LTCHs in its FY 2022 rules, the agency believes that SNFs have the capacity to begin collecting and reporting these data. As such, CMS notes that if this proposal is finalized, it would release a draft of the updated version of the assessment tool used for data collection "in early 2023," which would, according to the agency, provide sufficient lead time to prepare for the Oct. 1 data collection start date.

The AHA urges CMS not to adopt this proposal, and to retain the reporting deadlines adopted in the interim final rule. We disagree with CMS' assertion that the flexibilities and assistance granted by the agency during the PHE as well as the promising trends in COVID-19 vaccination and death rates cited in the rule have left providers "in a better position to accommodate reporting of the TOH measures and certain (Social Determinants of Health) Standardized Patient Assessment Data Elements." While CMS suggests that post-acute care providers "now have the administrative capacity to attend training, train their staff, and work with vendors to incorporate the updated assessment instruments into their workflows," the reality is that providers continue to struggle in the midst of an unprecedented and ongoing pandemic.

Nursing home staff have faced heavy strains even before the pandemic that have been exacerbated; according to the Kaiser Family Foundation, more than a quarter of nursing homes have reported staffing shortages as recently as March of this year. The additional costs of preparing for and treating COVID-19 patients—including but not limited to personal protective equipment, respiratory systems, medications and facility infrastructure changes to house additional patients—have, by necessity, taken priority over training staff to complete patient assessment tasks, many of which have questionable relevance and value, as we have noted in prior comment letters.

Part of CMS' rationale behind hastening the reporting of the recently finalized SPADEs is that implementing the elements under the newest domain of social determinants of health could increase the amount of data related to important social risk factors. We understand and agree with the importance of collecting, analyzing and using this data.

However, CMS also issued several requests for information (RFIs) in the various CY and FY 2022 proposed rules asking for feedback on potentially creating standardized

data collection elements across the entire continuum of care, not just post-acute care. It would create confusion and unnecessary administrative burden for CMS to hurriedly add data elements to the post-acute patient assessment tools because they happen to be available now, only to replace them with more reliable elements and strategies based on the feedback gleaned from the RFIs as well as CMS' other ongoing work on its Disparity Methods.

In addition, the updated version of the patient assessment instrument with the new measures and SPADEs is not yet available. CMS proposes in this rule that it would release a draft of the updated version "in early 2023." Considering current trends in disease incidence due to the ubiquity of the Omicron variants of the COVID-19 virus as well as the extension of the national PHE for COVID-19, it is possible that post-acute care providers might still be working under the constraints of the pandemic in early 2023. Thus, **we urge CMS to maintain the timeline for reporting of the new measures and SPADEs established in the May 2020 interim final rule.**

RFI on CoreQ: Short Stay Discharge Measure. CMS seeks feedback on the potential future inclusion of this measure in the SNF QRP. The measure assesses the percentage of individuals discharged in a six-month period from a SNF, within 100 days of admission, who are satisfied with their SNF stay. Specifically, it calculates the number of individuals who have an average satisfaction score on a five-point Likert scale of greater than or equal to three for the four questions on the CoreQ patient satisfaction questionnaire. The questionnaire is administered by customer satisfaction vendors.

The AHA appreciates CMS's approach to considering the best way of capturing patient satisfaction in SNFs. While it is vital to collect information on patient experience in SNFs, the CoreQ measure is not yet ready to be proposed for inclusion in the SNF QRP due to substantial logistical concerns that answers to the RFI in this rule may help elucidate. For example, the CoreQ questionnaire is a proprietary tool and thus requires administration by third party vendors (as opposed to a Consumer Assessment of Healthcare Providers and Systems, or CAHPS, survey, which is maintained by the U.S. Agency for Healthcare Research and Quality).

This raises questions about the burden of working with these vendors, including the cost. It is also unclear who will bear responsibility for transmittal, storage and quality assurance of the data collected. We encourage CMS to consider additional approaches to collecting patient satisfaction information before proposing the CoreQ questionnaire for required collection; just because the tool is available now does not mean that it is the best option to collect and analyze this important data.

SNF Value-based Purchasing Program (VBP)
The Protecting Access to Medicare Act (PAMA) of 2014 requires CMS to establish a VBP program for SNFs, beginning in FY 2019. The program must tie a portion of SNF

Medicare reimbursement to performance on either a measure of all-cause hospital readmissions from SNFs or a "potentially avoidable readmission" measure; currently, the VBP program is informed by the Skilled Nursing Facility 30-day All-Cause Readmission Measure (SNFRM). A funding pool is created by reducing each SNF's Medicare per-diem payments by 2%; as permitted under the statute, CMS distributes 60% of the pool back to SNFs in the form of incentive payments.

CMS proposes to suppress the use of the SNFRM for the FY 2023 VBP program in light of the COVID-19 PHE and instead assign performance scores and uniform payment incentive adjustments; CMS also would update the SNFRM's risk adjustment model to account for COVID-19 patients. In addition, the agency proposes several updates to the program as authorized by the Consolidated Appropriations Act of 2021, which allows the addition of up to nine new measures to the SNF VBP program.

Measure Suppression for FY 2023. As with the previous SNF VBP payment update, CMS once again proposes to suppress the use of SNFRM performance data for use in calculating payment adjustments for the FY 2023 payment year. As a result of this policy, the agency would assign all eligible SNFs a uniform performance score of zero, which would yield a payment adjustment of 1.2%, which is nearly two-thirds of of the 2% withhold, *and* which would still be applied across the board. SNFs with fewer than 25 eligible stays would receive a neutral payment adjustment.

We echo our comments on last year's rule in that we appreciate the challenges the agency faces in determining a fair way to account for the impact of the COVID-19 pandemic while maintaining its statutory duty to continue the program. **We also urge CMS to pay out the maximum 70% of the withhold for FY 2023,** which is allowed under PAMA: "the total amount of value-based incentive payments under this paragraph for all skilled nursing facilities in such fiscal year shall be greater than or equal to 50%, but not greater than 70%, of the total amount of the reductions to payments for such fiscal year." CMS chose to pay out 60% of the withhold in previous rulemaking, but we believe the agency could offset at least some of the losses from the program this way.

Technical Update to SNFRM to Risk Adjust for COVID-19 Patients. Because of the high prevalence of COVID-19 in SNF patients and the influence that history of COVID-19 has on readmission rates, CMS proposes to update the technical specifications of the SNFRM to account for patients with COVID-19, beginning with the FY 2023 program year. Specifically, CMS will add a variable to the risk adjustment model that accounts for the clinical differences in outcomes for these patients.

The AHA appreciates the approach CMS has taken to both maintain the integrity of the measure and incorporate differences in readmission rates for patients with a history of COVID-19. We understand that removing patients with COVID-19 from the measure cohort would reduce sample size for the measure's calculation to the point where many facilities might be excluded from the program; in addition, readmissions due to COVID-

19 might be prevented with appropriate infection control measures, so removing these patients from the cohort could miss important indicators of quality performance.

Together with the measure suppression policy proposed in this same rule, we think that CMS is making a good-faith effort to appropriately account for the increased burden of COVID-19 on SNFs while attempting to maintain the structure of the VBP program (which in the FY 2023 program year, is based upon the lone SNFRM measure).

Adoption of SNF Healthcare Associated Infections Requiring Hospitalization (HAI) Measure. CMS proposes to adopt this measure, beginning in the FY 2026 program year. The measure uses hospital claims data to estimate the risk-standardized rate of HAIs that are ostensibly acquired during SNF care and result in hospitalization. The measure was adopted for the SNF QRP in the FY 2022 SNF PPS final rule.

The AHA objects to the use of this measure in the SNF VBP program. There is no doubt that preventing HAIs in SNFs is a top priority, and that this measure conceptually fits CMS' Meaningful Measure priority area of "Make Care Safer by Reducing Harm Caused in the Delivery of Care: Healthcare-associated Infections." However, in the interest of achieving a streamlined and meaningful set of quality measures which will inform both care delivery and patient choice, we have several concerns regarding the specifications of this measure. In short, while we agree that measuring HAIs in SNFs is vital, the topic is so important and complex that CMS should develop a measure that will deliver more timely, accurate and actionable information rather than this measure under consideration. As such, the proposed measure is not appropriate for use in the SNF VBP program.

In evaluating whether there is a performance gap regarding HAIs in SNFs, the Technical Expert Panel (TEP) Summary Report states "the literature is scarce on the epidemiology of HAIs in SNF…Most other estimates on infections for SNF residents come from studies with the broader population of nursing home residents. Even these estimates are uncertain, and many are outdated." Although we do not argue the gravity of HAIs in SNFs, the inability to define the magnitude of the issue makes it difficult to identify benchmarks and goals.

The most glaring issue with the measure is its data source. Claims-based measures for health outcomes like infections are not usable for improvement, nor are they reliable indicators of performance. No current Medicare HAI measure is informed by claims. In other quality reporting programs, HAIs are reported via the National Healthcare Safety Network (NHSN) using chart-abstracted surveillance data; these data are based on certain counts of bacteria or certain test results gathered using very detailed instructions about what cases to include or not in the denominator and clinical definitions that only an infection prevention expert can interpret. This scientific process ensures data integrity and provides analytic tools that enable each facility to assess progress and identify where additional efforts are needed. A claims-based measure would not provide

this insight into clinical care for several reasons, including the multi-year lag between when claims are submitted and when data are used to inform measure performance.

CMS itself has found that administrative claims data are not reliable to inform HAI measure performance. For example, in a 2012 reliability analysis, CMS's contractor found that several claims-based hospital-acquired condition (HAI and patient safety indicator) measures had low and very low reliability; a 2012 Medicaid report on state reporting of the central line-associated blood stream infection (CLABSI) measure found that "administrative data (discharge or claims-based) substantially underestimate rates of CLABSI…effectively ruling out the use of administrative data at the current time as a legitimate approach to generating state-level, insurance-specific rates."

With regards to ICD-9 (now ICD-10) coding that informs claims, the 2013 National Action Plan to Prevent Health Care-Associated Infections noted "coded diagnosis of UTI, CAUTI, and CDI is neither a sensitive nor a specific indicator of clinical diagnosis." Several other studies show that administrative data is not able to reliably predict outcomes. The literature review conducted by contractor RTI International for the TEP cited additional studies that concluded that administrative data (i.e., claims data) results in under-, over- and misclassified reporting of health outcomes.

This measure's reliability also is questionable due to upstream data collection issues – namely, in detection of HAIs. As constructed, the measure would include only those SNF patients who go from a SNF to an acute care hospital, and for which the hospital submits a Medicare claim indicating *both* that the HAI was the principal admitting diagnosis AND had the HAI at the time of admission (i.e., with a present on admission code). At a minimum, this construction is likely to omit some SNF patients who have an HAI simply because the HAI is not either recorded as the principal diagnosis, or present on admission.

Nevertheless, the supporting documents for this measure conclude that existing HAI measures "all report on specific types on infections rather than on the overall HAI rate," and thus this measure, a composite of-sorts, would fill a gap. There is a reason that existing HAI measures are specified as such: tests for various infections are different, with different levels of sensitivity and specificity. With such varying inputs, it is difficult to see how a composite measure would provide accurate (and thus actionable) information. In addition, hospital tests of HAIs vary as well; it is possible that certain hospitals will be better able to detect HAIs than others, and thus SNF performance might be a factor of hospital data collection rather than true quality of care.

Overall, the measure's *actionability* – that is, whether providers will be able to use information gleaned from this measure to improve quality – is unclear. While there are common-sense practices that lower the likelihood of HAIs in SNFs, most specific clinical interventions are defined for the hospital setting rather than the SNF setting. Without clear clinical evidence of the relationship between providers' actions in a SNF and

residents' health as a result of their stay, the measure may not be able to detect usable information.

In addition, the construction of this measure makes the assumption that the only HAIs that truly "matter" are those resulting in hospitalization. Yet, successful HAI reduction efforts depend on the rapid and timely identification of infections so that their underlying causes – infection control, environmental, physical plant, etc. – can be addressed before they result in morbidity or mortality. That is why existing HAI measures use detailed surveillance definitions we describe above, and are collected using actual medical record data.

This approach ensures that providers know quickly which patients are infected, and can rapidly take infection control steps to protect other patients and staff from infection. Patients and providers cannot afford to wait two to three years to have incomplete claims-based data inform HAI reduction efforts. And for the reasons we describe below, this claims-based measure is likely to be a poor reflection of providers' actual performance.

Several factors at the patient and provider level influence outcomes, but they are not incorporated into the risk adjustment methodology for this measure. The supporting literature states "Research suggests that infection rates vary by provider characteristics" including staffing levels, staffing type (i.e., RN versus LPN), organizational structure (i.e., national chain versus independent facility), case mix, payer mix and adoption of infection surveillance and prevention policies.

Several other provider characteristics that may affect performance have not yet been investigated, including size, market (rural/urban or region) and whether the SNF is hospital-based. NHSN also collects information on patient days in admission, teaching status and where microbial testing is done (in the facility versus a commercial reference lab).

Patient-level characteristics, which are outside of the provider's control, also influence infection rates. Literature shows that social risk factors, including income level and race/ethnicity are associated with varying infection rates due to "more disparities in access to care among patients in the community than in SNFs," suggesting that certain residents are less likely to receive preventive care in the community and are thus at increased risk of infection. A more precisely-constructed HAI measure may not need to account for social risk factors because the surveillance definitions are specific enough to ensure they are truly reflecting those infections acquired in the course of receiving health care. But this measure does not have such definitions, making it vital that the role of social risk factors in performance be assessed and accounted for if appropriate.

Because of the myriad factors affecting outcomes like HAIs, a composite measure such as this one may not provide information that providers can use to address specific risks

to their patients. Even if the information gleaned from this measure were reliable, however, additional barriers remain to putting that data to use. While SNFs agree with the need to reduce HAIs, many operate under significant financial strain, and may not have the same depth of resources to apply to quality improvement efforts. We encourage CMS to deploy quality improvement support to help accelerate progress on reducing HAIs in SNFs.

This model has worked incredibly well for hospitals, as evidenced by the rapid progress of CMS's Hospital Innovation and Improvement Networks. It is conceivable that smaller SNFs with fewer resources could appear to perform worse than their competitors through no fault of their own (i.e., based on the influence of patient-level factors or differences in hospital surveillance). In the SNF VBP program, the described scenario would result in direct financial harm to already disadvantaged facilities.

In the end, accountability measures like this one are useful in value-based programs only when they can accurately characterize performance. SNFs would welcome a well-designed measure that can help them understand where they are performing well, and where they can improve. However, for the reasons outlined above, we are not confident that this measure delivers on that critically important task. It is also challenging to conceptualize an evaluation of facility performance based on claims filed by a totally different facility; we understand and appreciate that CMS is seeking measures that do not pose undue burden on providers (as claims-based measures require no data submission on the part of providers), but for some topics the burden is worthwhile. Burden is outweighed by the benefits of truly meaningful measures that uncover discrepancies in performance and provide actionable data that will result in better patient outcomes. We suggest CMS scrap this measure and develop one that is timely and actionable.

Adoption of Total Nursing Hours per Resident Day Staffing Measure. CMS proposes to adopt this measure, beginning in the FY 2026 program year. The measure uses auditable electronic data reported to the CMS Payroll Based Journal system to calculate total nursing hours per resident day. Hours include clinical and administrative duties as well as training.

The AHA does not support the inclusion of this measure in the SNF VBP program. This measure oversimplifies the relationship between higher RN staffing levels in nursing homes and improved care for residents and is unlikely to provide an accurate and meaningful indication of quality of care provided. The care needs and type of care provided to long-term care facility residents have changed since the prevailing studies were conducted. In this very same rule, CMS issues an RFI seeking feedback, evidence, data and best practices via 17 detailed questions, in order to inform future staffing requirements to ensure quality and safety. The RFI notes that current understanding of necessary staffing levels is insufficient to establish precise thresholds upon which to base assessments of quality.

It is incongruous that in the same rule that CMS acknowledges that it lacks evidence to determine appropriate levels of staffing, it also proposes to use a measure on levels of staffing in its value-based purchasing program.

First, the measure does not solely evaluate the use of RNs, but rather the total nursing hours for RNs, LPNs, nurse aides, medication aides/technicians and aides in training. While these clinicians are important parts of the caregiving team, there is less evidence available demonstrating a causal relationship between staffing hours for these professionals and patient outcomes. In addition, the recent report from the Office of Inspector General cited by the measure developer comes to the conclusion that regulatory bodies should take "additional steps to strengthen the oversight of nursing home staff." Yet, this measure provides only a tally of hours—which would include not only nursing but administrative duties. Therefore, it is difficult to see how this measure provides meaningful insights on quality of care.

CMS first began monitoring payroll-based staffing state in early 2019 in response to claims that facilities often have fewer staff on weekends; these data were used to update lists of nursing homes with significant drops in staffing levels specific to RNs, which were given to state survey agencies. If CMS's goal is to enhance oversight of nursing homes, this targeted surveillance is a more appropriate way to do so than using a broad count of general staff hours in a value-based purchasing program.

Adoption of Discharge to Community Measure. The AHA supports the adoption of this measure into the SNF VBP program. The measure is endorsed by NQF and has been used – and revised to improve accuracy – in the SNF and other post-acute quality reporting programs for multiple years. The measure is a useful indicator of outcomes that are of interest to patients.

RFI: Mandated Nurse Staffing Levels. As part of the Biden-Harris Administration's recent announcement regarding its work to improve the quality of US nursing homes, CMS uses this rule to announce its intent to propose minimum standards for staffing adequacy that nursing homes would be required to meet. While the agency does not make any proposals in this rule, it does note that it will conduct a new research study to help inform policy decisions related to the level and type of staffing needed to ensure safe and quality care and expects to issue proposed rules within one year. CMS also issues an RFI comprising several questions regarding available evidence to inform their future mandate.

The AHA and its members are committed to safe nurse staffing to ensure quality care and optimal patient experience in SNFs. However, implementing mandatory nurse staffing levels is an unsophisticated approach to a complex issue, one that would have serious negative consequences for the entire field if implemented poorly.

The AHA urges against the implementation of a “one-size-fits-all” approach, such as calculating flat ratios of staff to resident days or therapy hours. Ratios are a static and ineffective tool that cannot guarantee a safe health care environment or quality level to achieve optimum patient outcomes. The number of patients for whom a nurse can provide safe, competent and quality care is dependent upon multiple factors, including those not available in data submitted to the Payroll Based Journal – factors like the type and degree of illness, functional status and level of independence of residents, the makeup of the overall care team including caregivers who may not be nurses, the physical layout of the facility, and the experience and tenure of the nurses in question.

Further, staffing ratios are usually informed by older care models and do not consider advanced capabilities in technology or the interprofessional team-care model. These models incorporate not only nurses at various levels of licensure, but also respiratory therapists, occupational therapists, speech-language pathologists, physical therapists and case managers. A simple mandate of a base number of RNs, LPNs and/or CNAs limits innovation by emphasizing outdated staff roles and assigning responsibilities based on traditional job descriptions rather than what’s most efficient for the care team and best for the patient.

In short, specific staffing levels should be a clinical decision customized to the resident population and facility characteristics rather than a policy decision made agnostic of real-life situations. CMS does seek feedback on the resident and facility factors that should be considered in establishing a minimum staffing requirement, including how the facility assessment of resident needs and acuity impact the staffing requirement. These are reasonable questions, but the answer would result in setting standards based on factors like patient case mix; case mix and patient needs can change in an instant, and the intensity of care fluctuates throughout the year and even throughout the day – for example, patients might need more intense care during flu season; patients are in need of less intense clinical attention during discharge.

Determining universal appropriate minimum staffing levels might be an impossible task considering these variables. In addition, this proposed solution ignores deeper challenges facing the workforce. According to the American Association of Colleges of Nursing, schools of nursing have struggled for more than a decade to increase enrollments due primarily to an insufficient supply of faculty and clinical placement opportunities for students; the COVID-19 pandemic has increased the demand for nurses while further limiting access to clinical sites.

Mandating staffing levels is not only a simplistic response to the needs of nursing home residents and SNF patients, it also would exacerbate dire shortages. Faced with required staffing levels, we anticipate SNFs and other nursing homes may be forced to reduce their capacity or even close their doors when they are unable to meet these mandates. This would have a ripple effect across the entire continuum of care, as

general acute care hospitals, inpatient rehabilitation facilities and other health care facilities already struggle to find appropriate placement for their patients.

The Administration should consider other ways to bolster safety in nursing homes through clinical staffing, like improving the availability of educational programs and training placements for nurses so that staff at any level of licensure can confidently and independently carry out all duties under their license. There are also several innovative team-based care models shown to improve quality and patient satisfaction as well as employee satisfaction; the Administration can work with the American Organization for Nursing Leadership on helping SNFs and nursing homes better allocate resources through conducting technology assessments, promoting inter-professional collaboration and working toward joint accountability. A policy solution centered on clinical evidence and experience will be far more effective than a general mandate of number of nurses per patient.

Thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Rochelle Archuleta, AHA's director of policy, at rarchuleta@aha.org, on any payment-related issues, and Caitlin Gillooley, AHA's director of policy, at cgillooley@aha.org, regarding any quality-related questions.

Sincerely,

Ashley Thompson
Senior Vice President for Public Policy
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