May 28, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1802–P,
P.O. Box 8016, Baltimore, MD 21244–8016

Re: CMS–1802–P

Subject: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025

Dear Administrator Brooks-LaSure:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 14,000 long term and post-acute care facilities, or 1.06 million skilled nursing facility (SNF) beds and more than 3,000 assisted living communities. We represent the majority of SNFs across the country and a growing number of assisted living communities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly, and disabled individuals who receive services in CMS member facilities each day.

We appreciate the opportunity to provide comments on the "***Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025***" (SNF Proposed Rule).

In this letter, we focus our comments on the areas on which CMS requested comment including:

- Market Basket Index and SNF Rebasing
- Wage Index
- Consolidated Billing
- Skilled Nursing Facility Quality Reporting Program (SNF QRP)
- Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP); and
- Nursing Home Enforcement

As we have done in recent years, we include an extensive Appendix containing an independent *Analysis of SNF Beneficiary Characteristics* report commissioned from Avalere Health. The analysis continues to review changes in the characteristics and case–mix of beneficiaries treated in SNFs using available data spanning 2019 through 2023 that may be important to consider for

future payment policy decisions. The report includes figures, tables, and discussion from Avalere Health about notable trends that may be of interest to policymakers. The Appendix also includes an AHCA discussion about the potential causes and payment policy implications highlighted by Avalere that CMS and other policymakers should consider when evaluating where the PDPM payment model and other policies may be headed in the future.

Finally, as discussed in detail in the following comments, AHCA/NCAL strongly opposes all the proposed revisions to nursing home enforcement and support our position with statutory and regulatory rationale.

In conclusion, AHCA stands ready to work with CMS and other SNF stakeholders on this and other SNF payment and quality efforts. We would welcome the opportunity to continue CMS dialogue with CMS on these suggestions. As we have in the past, we will follow up with you to schedule a discussion. Please do not hesitate to contact Martin Allen at mallen@ahca.org if you have any questions.

Sincerely,

Mark Parkinson
President & CEO

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I. Proposed SNF PPS Rate Setting Methodology and FY 2025 Update

I.A. Rebasing and Revising the SNF Market Basket

AHCA Comments:

CMS is proposing a net market basket update (MBI) of 4.1% for FY25 which includes an unadjusted estimated market basket index for FY25, a negative productivity adjustment, and a positive forecast error adjustment for FY23 added into FY25. This update is consistent with prior years. For FY22 - FY24, the sector saw negative productivity adjustments, positive forecast error adjustments for FY23-F24, and the two-year parity adjustment.

AHCA Calculation of Market Basket and Adjustments FY22-FY25

Market Basket and Adjustments	2022	2023	2024	2025
Final Rule - Unadjusted Market Basket Index	2.70%	2.80%	3.00%	2.83%
Adjustment for Labor Inflation	N/A	1.10%	N/A	N/A
Forecast Error (Adjustment for prior period MBI estimate)	-0.80%	1.50%	3.60%	1.70%
Productivity Adjustment	-0.70%	-0.30%	-0.20%	-0.40%
Subtotal	1.20%	5.10%	6.40%	4.13%
Parity Adjustments (Two Years and Done)	N/A	-2.30%	-2.30%	N/A
Net Final Market Basket	1.20%	2.70%	4.00%	4.13%

Medicare FFS (Fee for Service) policy is the standard for reimbursement policy, and Medicare FFS rates are the basis for Managed Medicare contracts. We appreciate the update of the SNF market basket base year from 2018 base year to 2022 in the FY25 proposed rule, and the methodology used by CMS which resulted in previous increases. However, our members are concerned about annual FFS rate updates keeping up with actual expenses in the year they occur, and more broadly the impact on Managed Medicare rates and the long-term viability of skilled nursing facilities. In addition to inflationary pressures on current spending, future cost expectations are more daunting and will require CMS to hone its methods to keep up with actual costs. It is already difficult to recruit and retain qualified employees, and employment in the sector remains behind pre-pandemic levels as it contemplates the impact of the Minimum Staffing Final rule published earlier this year. Our internal analysis shows that employment levels are over 189,000 jobs lower in the nursing home sector since 2020 while other sectors in healthcare have stabilized or increased above pre-pandemic levels. Cost estimates for the minimum staffing rule exceed $6.5 Billion and over 100,000 additional employees. The industry must continue to attract and retain employees to the nursing home sector and contend with increased competition from other healthcare providers for the same labor pool. This requires nursing homes to continue increasing wages and benefits to recruit and retain staff. These salary expenses will exceed increased revenue from Medicare and other payers. We urge CMS to consider using a prospective adjustment for labor inflation in FY25 as was done in FY2023 and engage with the SNF community in researching ways that the additional costs of the Minimum Staffing Final rule can be reflected in future fiscal years so that additional funding occurs to meet CMS' staffing mandate.

I. B. Proposed Changes to SNF PPS Wage Index (89 FR 23451)

CMS lists multiple updates and proposed changes to the SNF PPS Wage Index throughout the proposed rule. AHCA includes these sections below but has placed all our comments and recommendations at the end of this section.

For FY 2025, CMS is proposing to adopt OMB Bulletin No. 23–01 which contains several significant changes including new CBSAs, urban counties that would become rural, rural counties that would become urban, and CBSAs that would split apart.

Background on Core-Based Statistical Areas (CBSAs) for FY 2025 (89 FR 23431 – 23433)

CMS has used hospital inpatient wage data for the SNF wage index since the start of SNF PPS.

CMS proposes to continue this for FY 2025, because without SNF specific wage data, using IPPS (Inpatient Prospective Payment System) hospital wage data is deemed appropriate for the SNF PPS. Differences exist in how the policy is applied to Hospitals vs. SNFs.

CMS does not use the hospital data occupational mix adjustment for SNFs. CMS believes using hospital data exclusive of the occupational mix adjustment continues to be appropriate for SNFs.

CMS does not allow SNFs the same process that Hospitals may apply for such as geographic reclassifications under section 1886(d)(8) and (d)(10) of the Act and does not apply the rural floor under BBA 1997 and the outmigration adjustment under section 1886(d)(13) of the Act.

To accommodate volatility, CMS instituted in FY23 a permanent 5% cap in annual changes on decreases to a SNF's wage index from the prior year, regardless of the reason for the decline.

CMS used CBSAs from OMB Bulletin No. 20-01 for FY22 through FY 24. For FY25, CMS proposes to use OMB Bulletin No. 23–01. It supersedes No. 20–01 and continues revising CBSA delineations.

(1) Micropolitan Statistical Areas in Rural Wage Index (89 FR 23452)

The SNF PPS statewide rural wage index is determined using data from hospitals located in non-MSA areas, and the statewide rural wage index is assigned to SNFs located in those areas. Micropolitan Areas encompass smaller population centers and contain fewer hospitals than MSAs, Recognizing Micropolitan Areas as independent labor markets would increase the potential for dramatic shifts in year-to-year wage index values because a single hospital (or group of hospitals) could have a disproportionate effect on the wage index of an area. CMS recognizes this as problematic and creating instability in the payment levels from year-to-year, which could make fiscal planning for SNFs difficult if we adopted this approach. For these reasons, Micropolitan Areas are included in the state's rural wage area. CMS proposes to continue to treat Micropolitan Areas as 'rural' and to include them in the state's rural wage index.

(2) Urban Counties That Would Become Rural Under Revised OMB Delineations (89 FR 23452)

CMS is proposing to implement new OMB statistical area delineations beginning in FY 2025 for the SNF PPS wage index. CMS states that a total of 54 counties (and county equivalents) that are currently part of an urban CBSA would be considered located in a rural area for the purpose of calculating the rural wage index, for SNF PPS payment beginning in FY 2025. CMS recognizes that rural areas typically have lower area wage index values than urban areas, and SNFs located in these counties may experience a negative impact in their SNF PPS payment due to the proposed adoption of the revised OMB delineations. To accommodate that, these SNF providers currently located in an urban county that would be considered rural should this proposal be finalized, would utilize the rural unadjusted per diem rates found in table 4 for determining their payment rates beginning on October 1, 2024.

(3) Rural Counties That Would Become Urban Under Revised OMB Delineations (89 FR 23454)

CMS proposes changing the statistical area delineations for 54 counties (and county equivalents) in rural areas to urban areas along with the revised OMB delineations. For calculating the area wage index under the SNF PPS, the wage data for hospitals in the counties listed in Table 23 would be included in their new urban CBSAs. Typically, SNFs located in an urban area would receive a wage index value higher than or equal to SNFs located in their state's rural area. SNFs located in a rural county that would be considered urban should this proposal be finalized would utilize the urban unadjusted per diem rates per Table 3, as the basis for determining the payment rates for these facilities beginning 10/1/24.

(4) Urban Counties That Would Move to a Different Urban CBSA Under Revised OMB Delineations (89 FR 23455)

In addition to rural becoming urban and vice-versa, several urban counties would shift from one urban CBSA to another urban CBSA under CMS' proposal to adopt the new OMB delineations. In other cases, if CMS adopts the new groupings, counties will shift between existing and new CBSAs, changing the constituent makeup of the CBSAs. CMS acknowledges both negative and positive impacts can occur.

(5) Change to County-Equivalents in the State of Connecticut (89 FR 23457)

OMB Bulletin No. 23–01 replaced 8 counties in Connecticut with 9 new ''Planning Regions.'' which serve as county-equivalents within the CBSA system. CMS proposes to adopt the planning regions as county equivalents for wage index purposes. CMS believes it is necessary to adopt this change from counties to planning region county-equivalents to be consistent with OMB updates. CMS has provided a crosswalk with the current and proposed county and county-equivalent codes and CBSA assignments.

(6) Transition Policy for FY 2025 Wage Index Changes (89 FR 23458)

CMS believes the permanent 5 percent cap implemented in FY23 mitigates disruptive impacts on SNFs negatively affected by the proposed adoption of the revised OMB delineations.

Capping reductions at 5% ensures that a SNF's wage index would not be less than 95 percent of its final wage index for the prior year. Wage Index changes do not result in any change in estimated aggregate SNF PPS payments due to budget neutrality policy.

CMS believes that implementing the new OMB delineations will result in wage index values being more representative of the actual costs of labor in a given area.

CMS recognize that some SNFs (43 percent) would experience decreases in their area wage index values because of this proposal, though less than 1 percent of providers would experience a significant decrease (that is, greater than 5 percent) in their area wage index value. CMS also realize that many SNFs (57 percent) would have higher area wage index values after adopting the revised OMB delineations.

CMS recognizes that SNFs in certain areas may experience reduced payment due to the proposed adoption of the revised OMB delineations and has finalized transition policies to mitigate negative financial impacts and provide stability to year-to-year wage index variations.

CMS's long held opinion is that revised labor market delineations should be adopted as soon as possible to maintain the integrity of the wage index system.

CMS invites comments on the proposed changes to the SNF PPS Wage Index for FY24 including the implementation of revised labor market area delineations.

AHCA Comments:

AHCA urges CMS to use the existing statutory authority under BIPA to establish a SNF-specific Wage Index. We also encourage CMS to allow geographic reclassification in the same manner as hospitals may under the policy codified at 42 CFR § 412.230 "Criteria for an individual hospital seeking redesignation to another rural area or an urban area".

In light of the changes created by applying the updated OMB and census data, we appreciate and support the continued application of the -5% floor which CMS started in FY23. However, these updates have created substantial variability in the reimbursement rate that in some instances result in areas of the country where the update adjustment is less than the reduction in payment caused by the changes in the wage index. Thus, even with the 5% floor, the situation may not be sustainable for some SNFs already struggling to remain open and fully staffed.

As a result of this situation, AHCA urges CMS to adopt in the final rule for FY25 a process to allow SNFs to seek redesignation to another rural or urban area, consistent with the process established for hospitals at 42 C.F.R. §412.230. If CMS continues to apply the hospital wage index to SNFs, about which we have serious concerns, it should also apply the redesignation process that hospitals can access. Additionally, we note that the –5% floor to wage index changes does not equitably protect providers that see a significant reduction in their geographic wage index multiplier AND are also in a county with a wage index classified as Rural in FY 2024 that is proposed to be classified to Urban on FY 2025. We note that the sum of the component base rates before wage index adjustors for Urban providers that remain Urban, or Rural providers that remain Rural increase 4.1% as CMS has indicated as a net market basket increase for FY 2025. However, As Table 3 and Table 4 of the proposed rule indicate, the sum of component base rates before wage index adjustors are applied are different depending on the Urban versus Rural designation, with Urban base rates overall being lower than Rural base rates.

As a result, providers in counties classified as Urban in FY 2024 and reclassified as Rural in FY 2025 will see a net component base rate increase of 7.8% before the wage index adjustment is applied, while counties classified as Rural in FY 2024 and reclassified as Urban in FY 2025 will see a net component base rate increase of only 0.55% before the wage index adjustment is applied. While only 54 geographic areas are adversely impacted by the drop in component base rates when converting from a Rural to an Urban classification, 13 of those counties will see a net rate reduction in FY 2025 even after the wage index floor is applied. We ask CMS to look into possible approaches within available authorities to further mitigate significant negative component base rate swings when a provider's county designation is reclassified from Urban to Rural or vice versa.

Moreover, with the looming implementation of the SNF Minimum Staffing Rule, we urge CMS to work closely with the community to establish a SNF-specific wage index. The differences between a hospital and skilled nursing facility are significant and the SNF expenditures necessary to implement the SNF Minimum Staffing Rule will cause SNF data to diverge materially from hospital data over time. CMS estimates the additional annual cost of final rule will be more than $4 billion, while an analysis commissioned by AHCA determined that the cost would be greater than $6 billion. Similarly, CMS estimates that RN (Registered Nurse) and NA (Nurse Aides) wages will grow annually at 2.31%, while the nursing home resident population will remain stable over ten years. Based on recent inflationary and workforce trends identified in federal data, AHCA is deeply concerned that these estimates do not account for what is likely to

be much faster growth and an increasing resident population. Even so, the hospital wage index is not structured to capture these significant changes; thus, another approach is needed.

We disagree with the statements in the preamble of both the SNF Minimum Staffing Rule and the Proposed Rule that adopting a SNF-specific wage index is not feasible. First, CMS has suggested that all cost reports would have to be audited. In contrast, we believe that appropriate sampling could be used to minimize the burden of such audits and still allow CMS to obtain the data necessary to establish the new wage index. Appropriate sampling (what the preamble may refer to as "spot auditing"), which is used in other parts of CMS that audit claims for medical necessity for example, would reduce the burden on providers, CMS, and the contractors. In addition, the "auditability" or quality of wage and hour data on Medicare Cost Reports has improved due to increased use of "one stop" payroll solution companies that handle employee pay and employer payroll tax reporting instead of the use of in-house processes. In addition, SNF providers have almost 8 years of experience reporting employee hours under PBJ (Payroll Based Journal) since mandatory collection of PBJ data began in July 2016. We urge CMS to work with AHCA and others in the community to find a way to address these concerns and to model the SNF-specific wage index before the Minimum Staffing Rule requirements take effect. Without a SNF-specific wage index policy, there will likely be insufficient funds to support the implementation of the new rule, which would place beneficiary access to SNFs at risk. Simply put, if SNFs cannot meet the staffing requirements because there is not sufficient funding for the staff, they will have to reduce their capacity or potentially close. It is in the Agency's interest as well as that of the providers and patients to find an immediate solution to the problems that using the hospital wage index creates.

II. Additional Aspects of the SNF PPS

II.A. Consolidated Billing (89 FR 23438)

CMS is solicited public comments identifying HCPCS codes in any of these five service categories (chemotherapy items, chemotherapy administration services, radioisotope services, customized prosthetic devices, and blood clotting factors) representing recent medical advances that might CMS criteria for exclusion from SNF consolidated billing. CMS may consider excluding a particular service if it meets the narrow criteria specified. And requested that commenters identify the specific HCPCS code associated with the service in question and their rationale.

AHCA Comments:

AHCA appreciates the opportunity to offer suggestions regarding what medications we believe CMS should consider excluding from the SNF consolidated billing requirements, and our rationale. We defer to coding experts to identify the specific HCPCS codes that would apply to our recommended medications to be listed on the consolidated billing exclusion list:

- Imatinib Mesylate: The average retail price of this medication is $8,999.98 for a 30-day supply of 400-mg tablets.
- Jakafi (ruxolitinib): The cost for a 60-day supply of oral 5-mg Jakafi tablets is about $18,068.
- Erleada (apalutamide): The cost for 120 tablets 60 mg is about $15,713.
- Tafinlar (dabrafenib): The cost for 120 tablets 50 mg is about $11,912.

II. B. RFI Update to PDPM Non-Therapy Ancillary Component (89 FR 23459)

CMS stated in the FY19 SNF PPS final rule that it would consider revisiting the list of included NTA comorbidities and the points assigned to each condition or extensive service, based on changes in the patient population and care practices over time (83 FR 39224). This request for information (RFI) solicits comments on the methodology CMS is currently considering for updating the NTA component that could be proposed in future rulemaking.

Specifically, CMS is considering several changes to the NTA study population as a foundation upon which to update the NTA component, including:

- Updating the years used for data corresponding to Medicare Part A SNF stays, including claims, assessments, and cost reports from FY14 – FY17 to FY19 – FY22.
- Using the same subset population used for the PDPM parity adjustment recalibration by excluding stays with either a COVID-19 diagnosis or stays using a COVID-19 PHE- related modification under section 1812(f) of the Act.
- Updating the methodology to only utilize SNF Part A claims and the MDS, and not claim types from other Medicare settings (that were used as a proxy to develop PDPM).
- Modifying the overlap methodology to rely more upon the MDS items that use a checkbox to record the presence of conditions and extensive services whenever possible, while allowing for potentially more severe or specific diagnoses to be indicated on MDS item I8000 when it would be useful for more accurate patient classification under PDPM.
- Prioritizing the reporting of conditions on the MDS by raising the cost threshold for selecting the overlapping CC or Rx CC definitions from any additional cost to five dollars in average NTA cost per day, which is the amount generally associated with a one-point NTA increase.

To facilitate discussion and comment, Table 27 in the proposed rule contains an example of a revised Conditions and Extensive Services Used for NTA Classification that would be adopted should the changes in this RFI be adopted in future rulemaking. The table includes the specific comorbidity, percent of SNF stays observed from FY19 – FY22, the average NTA costs, and reassigned NTA point values for each NTA comorbidity.

AHCA Comments – General:

- **Overall, AHCA is concerned about the methodology that CMS is considering proposing in future rulemaking particularly because insufficient information is provided to provide meaningful and specific feedback, and we believe the suggested methodology does not appear to address the primary CMS objectives stated in the FY 2019 SNF PPS final rule of *"…basing changes in the patient population and care practices over time"* but instead would create significant instability.**
- **AHCA recommends that CMS publish more detailed data necessary to allow stakeholders to assess the methodology and provide meaningful comment.**

- **AHCA requests that CMS provide estimates on the net NTA component payment impacts of any potential changes to the table of NTA comorbidities and extensive services used for NTA case-mix assignment.**
- **AHCA recommends that CMS meet with stakeholders, including convening technical expert panel to work through potential NTA component changes in a transparent manner.**

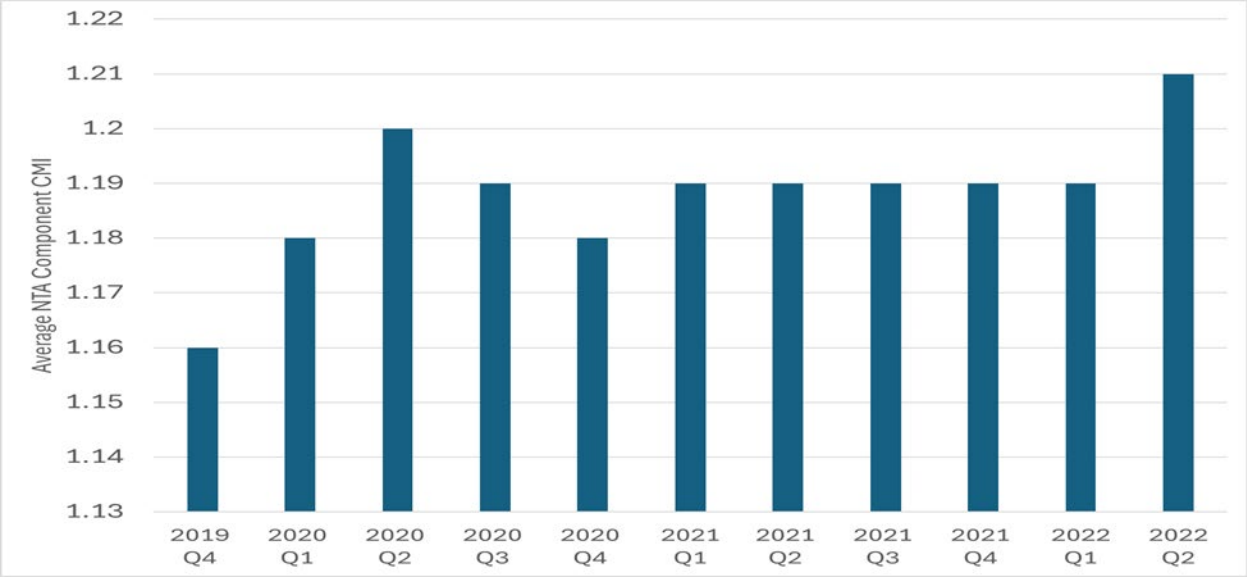
It is difficult to respond to the RFI as there was limited information included to explain/justify the conclusions and suggested approaches outlined in the RFI. References to the April 2018 PDPM technical report are meaningless unless CMS shares data detail comparable to that shared in the prior Technical Report. Table 27 in the RFI does not include enough detail to allow for stakeholders to assess the proposal. Also, the RFI did not mention the net financial impacts of the suggested changes to the NTA component offered in the RFI. For example, the question of budget neutrality is not addressed, but is central to understanding the impact of the potential methodology?

To allow for meaningful comment, we request that CMS provide additional background about why the agency is considering such a significant redesign of the PDPM NTA component, including replacing over two-thirds of the data elements that feed the NTA component case-mix determination just one year after completing the parity-adjustment process that was intended to assure that the SNF PDPM payment model was resulting in aggregate payments comparable to what was expected. We believe it may be premature to redesign the system unless it is clear how the parity adjustment has taken full effect.

The 4.6 percent total negative parity adjustment included adjustments to the NTA component case mix weights, and resultant payment rates for each of the six NTA component categories. From publicly available data, it does not appear that there was a significant shift in NTA component weights observed after the application of the parity adjustment. Given that, it seems inappropriate to consider a change that could destabilize the PDPM payment model when the data one would expect to drive such a change does not appear to exist..

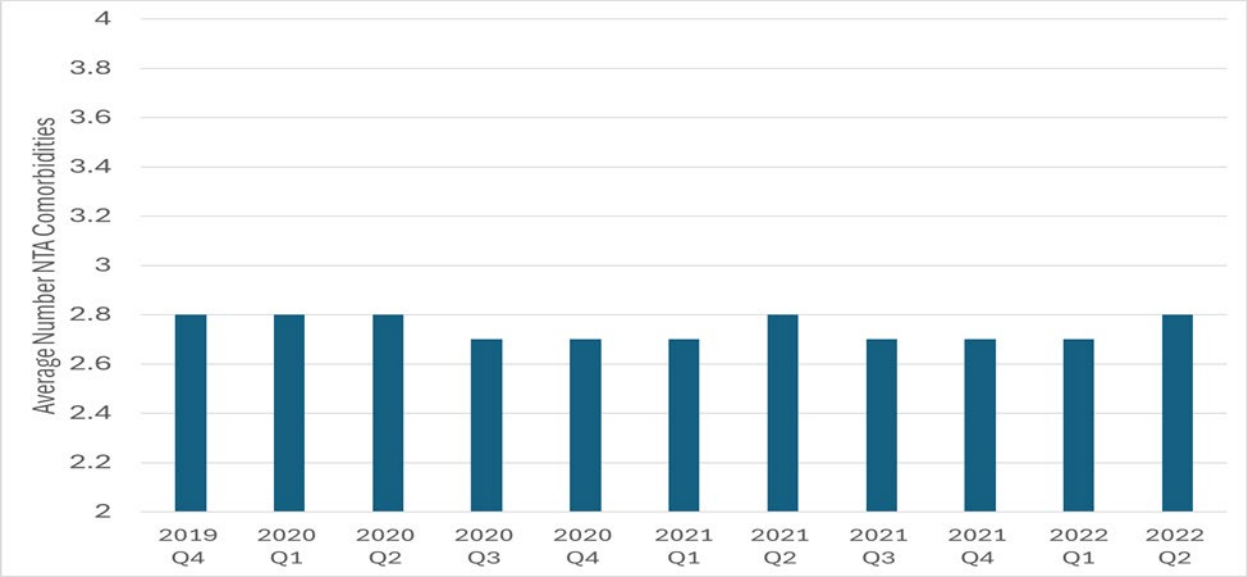
For example, although there may have been certain fluctuations in the reporting of some individual NTA component conditions or extensive services from the onset of the PDPM payment model in October 2019 or due to COVID-19 impacts or coding practice changes, the overall aggregate NTA component weights remained relatively stable. From our *AHCA/NCAL LTC TrendTracker* Analysis of NTA component aggregate case-mix values for all SNF PPS 5-day assessments, we note that from first full month of the onset of the COVID-19 PHE in April 2020 through June 2022 (including admissions with a COVID-19 diagnosis and/or resulting from a COVID-19 waiver) the NTA component average CMI per quarter only varied between 1.18 and 1.21, with six of the nine quarters NTA CMIs averaging 1.19. (Figure 1).

Figure 1. Average PDPM NTA Component CMI – Per Quarter (Calendar Year)



Along a similar vein, we have been tracking the average NTA total points comorbidity score for all NTA component condition and extensive service items reported as an early indicator of potential unusual coding practices. These trends include all 5-day assessments (including admissions with a COVID-19 diagnosis and/or resulting from a COVID-19 waiver). These aggregate trends reflected in Figure 2 were extremely stable by quarter, fluctuating between 2.7 and 2.8 NTA comorbidity points. These map midway between the ND and NE NTA component case-mix groups, or the second and third lowest value NTA component groups. This again suggests the current NTA component model appears to be stable.

Figure 2. Average Number of NTA Comorbidities Score – Per Quarter (Calendar Year)



We believe that instead of using a non-specific blanket mathematical model to revise the NTA conditions and extensive services list as contemplated in the RFI, CMS should analyze the reporting patterns of the existing MDS and claim items used for the NTA component and other administrative data for potentially new items in a transparent manner with stakeholder input to

identify if there are computation errors, rational and justifiable changes observed, or if there are unexplained coding behavior changes.

If there are unexplained coding behavior changes, then further analysis and discussion is necessary to determine if the coding practice changes are ubiquitous across most SNF providers or are associated with outlier provider coding. For example, in prior comments we pointed out that the MDS PHQ-9 resident mood item trends indicting the presence of depression, and that impact the PDPM Nursing component, did not appear to be totally explained by the impact of the COVID-19 PHE and associated infection control practices (e.g., in-room isolation, visitation restrictions). We have suggested further discussions of that trend previously. However, we expect the depression coding trends to change notably beginning with October 2023 5-day assessments as CMS changed the depression indicator resident mood interview code item set on the MDS from the PHQ-9 to the PHQ-2 to 9, which makes it much more difficult for a resident to classify for a depression adjustment under the PDPM payment model. We have more discussion about the depression item trends in the Appendix of this comment letter.

With respect to individual NTA item trends that appear to be unusual, earlier this year CMS had observed that the reporting of a particular MDS item (I5600), that is worth one point towards the NTA component classification, has been trending upward significantly without an obvious explanation. We initiated a preliminary analysis of MDS item *I5600 - malnutrition (protein or calorie) or at risk for malnutrition*, which is further discussed in the Appendix of this comment letter. We agree that this item, which has very vague coding guidance in the MDS-RAI manual, does need to be examined more closely as the prevalence of SNF PPD 5-day assessments with this diagnosis checkbox item entered has increased from 16 percent in October 2019 to 42 percent through June 2023. These examples highlight the importance of our request for CMS to meet with stakeholders, including convening a technical expert panel to work through potential NTA component changes in a transparent manner.

Below we detail our specific comments on the five key potential future changes to the PDPM NTA component offered in the RFI request.

<u>Change 1</u>: Updating the years used for data corresponding to Medicare Part A SNF stays, including claims, assessments, and cost reports from FY14 – FY17 to FY19 – FY22.

AHCA Comments:

- **AHCA recommends that CMS exclude any data for NTA component analysis prior to at least FY 2022 as the earlier data is fatally unstable and cannot be used to reflect changes in the patient population and care practices.**

Without additional detailed information of all potential conditions and extensive services considered for NTA classification that resulted in the 50 listed item rows in Table 27 of the NPRM it is impossible to assess the appropriateness of the suggested. Some observations we can make with the limited data presented are:

1. Of the 50 item rows offered, over one-third of the rows (17) represent new conditions or extensive services that have not been present in the NTA component previously. This suggests significant instability in the underlying FY 19-FY-22 data being considered. We have seen no data no data that could help explain why over one-third of the NTA component item rows were replaced.

2. Of the 33 out of 50 NTA item rows in Table 27 of the RFI that we could compare with the April 2018 PDPM Technical Report referenced in the RFI, we noted several anomalies that require further analysis to rule out methodological logic or calculation errors, such as:
    a. NTA Item Point Shifts – Of the 34 conditions and extensive services in the current NTA component rows valued at one point:
        i. Half of them (17) would be removed per Table 27 in the RFI.
        ii. One item row (Invasive Mechanical Ventilator or Respirator) would lose three points dropping from 4 to 1.
        iii. Only one gains 2 points (Cystic Fibrosis), while two lose two points (Parenteral IV Feeding: Level High, and Level Low).

        It appears these shifts are a result of the OLS estimates.
    b. OLS Estimate Shifts – 14 of the 33 item rows that can be compared with the 2018 PDPM Technical Report reveal shifts of greater than $5, with 10 of the 14 losing value. **Extreme examples of OLS estimate drops for conditions and extensive services usually require expensive medical equipment and/or medications that appear to be implausible include:**
        i. Parenteral IV Feeding High: Drops from $67.74 to $46.27.
        ii. Invasive Mechanical Ventilator or Respirator: Drops from $39.65 to $9.79.
        iii. Parenteral IV Feeding Low: Drops from $32.79 to $14.26.
        iv. Wound Infection Code: Drops from $16.49 to $6.96.
        v. Multi-Drug Resistant Organism (MDRO): Drops from $12.19 to $4.57.
        vi. Morbid Obesity: Drops from $10.27 to $5.02.

        We might be able to understand instability if the original OLS estimates were based on CC and RxCC derived estimates in the absence of MDS data, however, all of the above OLS estimate drops except for Morbid Obesity were based on MDS data that was available in the original 2018 PDPM Technical Report. We are concerned that there may be a logic flaw in the analytic approach, inappropriate source data used, or computation error that requires further evaluation.
    c. Percent of Stay Shifts – In addition to the 16 NTA item rows suggested for removal that we have no information on, we also note 5 of the 33 item rows that can be compared with the 2018 PDPM Technical Report data show a shift of more than one percent prevalence.
3. AHCA data analysis of PDPM MDS item trends that we have discussed in prior SNF PPS payment rule comments and that we continue to discuss in the Appendix of this comment letter suggests that most of the SNF Part A population volatility related to the COVID-19 pandemic began to stabilize during FY 2022, and even more so beginning in March 2022, as most of the nursing home population and staff were vaccinated and COVID-19 therapeutics were more widely available. As such, the earliest year we believe should be considered for potential inclusion in NTA component revisions is FY 2022.

With the limited information presented in the RFI and our further discussion regarding Change 2 below, AHCA believes the NTA data between FY 2019 and at least FY 2021 is fatally unstable and should not be used to reflect changes in the patient population and care practices necessary to revise the NTA component conditions and extensive services item list and values.

<u>Change 2</u>: Using the same subset population used for the PDPM parity adjustment recalibration by excluding stays with either a COVID-19 diagnosis or COVID-19 PHE waiver stays.

AHCA Comments:

- **AHCA recommends that CMS to consider and evaluate <u>not excluding</u> recent data for NTA component analysis in order to best reflect changes in the patient population and care practices, however this analysis must exclude data from any period prior to at least FY 2022.**

We are extremely grateful for the thoughtful, deliberate, and transparent approach CMS took during the SNF PPS parity adjustment process in order to assure that the net Medicare payments changes from year-to-year were attributed to changes in the market basket, the SNF patient population characteristics, and any deliberate policy-related changes and not related to the change in payment models from the Resource Utilization Groups (RUG) case-mix design to PDPM. We note that a key rationale for the CMS decision to exclude patients with a COVID-19 diagnosis from the analysis was that the PDPM payment model did not contemplate the impact of a novel, once a century pandemic where there were not available vaccines or therapeutics available for many months, and national dissemination for many more.

Additionally, a key rationale for excluding certain SNF patients from the parity adjustment analysis was that the patients were admitted to a Part A stay without a 3-day qualifying hospital stay (QHS), or had a benefit period extended for up to 100 additional benefit days was that the PDPM design did not contemplate the significant variability of clinical complexity and acuity that could be present with this new and temporary shift in the SNF Part A population. By conducting the parity adjustment analysis using only SNF admissions resulting from a 3-day QHS and residents without a COVID-19 diagnosis, CMS was better able to isolate the relative SNF Part A payment changes that were directly attributed to the change from RUGs to PDPM. In other words, the parity adjustment was completed to align the aggregate PDPM payments in a budget neutral manner with what the RUGs payment would have been.

However, we believe that using the same approach outlined in the NTA RFI may be inappropriate for considering changes to the NTA component list of conditions and extensive services, and the resultant point values attributed to the individual item rows. The PDPM payment model, including the NTA component, seeks to best reflect the costs of care for the patient population that is covered under Medicare Part A, not how the benefit was obtained, or whether a new viral strain or new condition is present.

As CMS states, an intention of the contemplated changes to the NTA component conditions and extensive services classification points table, the RFI approach being contemplated should be *"…based on changes in the patient population and care practices over time."* **It should also be based on <u>current</u>, <u>stable</u>, and <u>complete</u> data that reflects current SNF Medicare Part A patient population and care needs today that are not expected to change significantly over time**. We are deeply troubled that the NTA revision approach being considered does not appear to meet these additional criteria for the following reasons.

First, we do not believe NTA component data obtained prior to the COVID-19 PHE should be considered because, as CMS acknowledged in the FY 2024 SNF PPS final rule, there has been a shift in the SNF patient population from what it was before the pandemic. In other words, the overall SNF population has a higher acuity reflected by more complex conditions and comorbidities. Using NTA data from this period would not reflect current SNF Part A population NTA care needs.

Second, we do not believe NTA component data obtained from the onset of the COVID-19 PHE through at least the end of FY 2021 should be considered. This is because of the instability of the SNF patient population during a period from when there were no COVID-19 vaccines or therapeutics available through the period where a substantial portion of SNF residents and staff were vaccinated and effective therapeutics were relatively available. The best stabilization seems to appear starting in March 2022. An additional complication could be how provider relief funds were attributed during this period and captured in the NTA analysis results presented in Table 27 of the proposed rule. As a result of the skewing of the resident population along with the associated skewed NTA need and use, we believe data from before FY 2022, or better, the March 2022 period does not reflect current SNF Medicare Part A resident NTA needs and would result in inappropriate changes to the PDPM NTA conditions and extensive services table.

- **AHCA Recommendation to Include Data from Part A Stays With a COVID-19 Diagnosis -Excluding Data from Any Period Prior To At Least FY 2022.**

Ignoring the NTA costs associated with beneficiaries with a COVID-19 diagnosis would perpetuate a payment model design limitation that resulted in the need to exclude persons with a COVID-19 diagnosis from the parity adjustment analysis in the first place. The costs of COVID-19 care need to be incorporated into the PDPM payment model, including any updates to the NTA component – not excluded. For example, COVID-19 patients require active single occupancy room isolation procedures per current policy and associated NTA medications and treatment supplies that would not be captured if persons with a COVID-19 diagnosis were excluded from the NTA analysis. Additionally, COVID-19 therapeutics were only recently introduced, are very expensive, and with the recent commercialization of these therapeutics, the costs, of these products no longer available to SNFs for free since the PHE has ended and are not excluded from consolidated billing. We have heard from our members that the costs of these COVID-19 therapeutics per course of treatment are significant. For example, one provider stated *"Paxlovid (Nirmatrelvir-Ritonavir) and Lagevrio (Molnupiravir) will be high-cost meds with a course of therapy for Paxlovid or Lagevrio ranging between $1400 - $1800 depending upon the dose. For Medicare Part A patients, this would be a high-cost medication billed to the facility."* In the absence of a significant period of commercialization of these high-cost COVID-19 therapeutics, we believe CMS needs to meet with stakeholders to identify appropriate cost proxies before any modification of the NTA component is finalized.

Finally, data from a stable period after COVID-vaccine/therapeutics were widely available patient population is necessary to most accurately reflect the NTA costs of the current stable SNF Part A population. From our analysis of multiple trends during the COVID-19 PHE, in earlier SNF payment rule comment letters and reflected in the Appendix of these comments, it appears that most trends reflecting clinical complexity of the SNF Part A population started to stabilize during FY 2022, either at pre-pandemic patterns, or stabilized at patterns above or below pre-

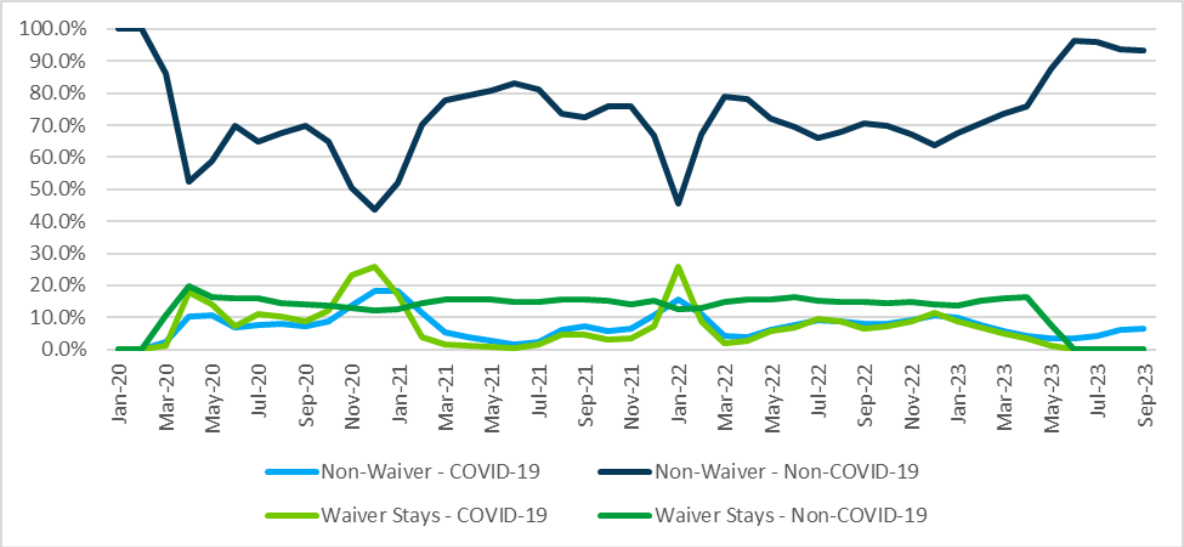
pandemic levels. The important factor is that they started to stabilize during FY 2022, particularly by March 2022, which suggests that the Medicare Part A SNF population, including those with a COVID-19 diagnosis best reflects the "new normal" that any NTA component revisions should be based on.

- **AHCA Recommendation to Evaluate Including Data from Part A Stays Resulting from A 3-Day Qualifying Hospital Stay Or Benefit Period Waiver - Excluding Data from Any Period Prior To At Least FY 2022.**

Not taking into account the NTA costs associated with beneficiaries that obtained SNF benefits via a 3-day qualifying hospital stay (QHS) of benefit period waiver could be skewing the true NTA costs of care for medically complex stays and could be contributing to the massive potential replacement of over one-third of the Conditions and Extensive Services Used for NTA Classification listed in Table 27 of the proposed rule. We believe the rationale we described above to exclude COVID-19 stays prior to at least FY 2022 in the NTA analysis also applies with stays initiated or extended under COVID-19 PHE waivers and would improve the analysis by focusing on a more stable population reflecting today's resident NTA needs. While it is unknown exactly how many of these individuals would have obtained a 3-day qualifying hospital stay prior to their admission during the PHE from FY 2022 through the end of the PHE in May of 2023, CMS in prior rulemaking and AHCA's analysis of waiver use indicates that only a small percentage of SNF admissions during the PHE were related to waiver use.

Additionally, of those, a large portion of waivers were for persons with a COVID-19 diagnosis, particularly during COVID surges. Between April 2020 and January 2022, the waiver stays including COVID-19 diagnoses on admission ranged from 0.5 percent to 25.9 percent of SNF monthly admissions. In contrast, the percentage of SNF waiver admissions for conditions not related to a COVID-19 diagnosis remained steady throughout the PHE. After an initial peak of 19.9 percent of SNF admissions under a waiver without a COVID-19 diagnosis in April 2020, the prevalence of these waivers remained relatively stable every month at a level between 12.2 percent and 16.3 percent of admissions. See Figure 3 for an overview of COVID-19 waiver use compared to other types of SNF admissions. Because the clinical qualifications for a waiver were identical to the requirements for Medicare admissions listed on Chapter 8, Section 30 of the Medicare Benefit Policy Manual, with the exception of the 3-day QHS, it is quite plausible that important and relevant that the clinical complexity of these stays and NTA needs better reflect the current day SNF admission population than the analysis CMS completed for this RFI that excluded these stays from the NTA analysis.

Figure 3. Percentage of SNF Medicare Part A Stays Jan 2020 Through Sept 2023 – By Waiver and COVID Diagnosis Status



We believe it is imperative for CMS to provide analysis of NTA use of these groups during FY 2022 or beginning in March 2022 through the end of the PHE to see if there are similarities or differences to the patient population after the PHE ended when waivers were no longer available. Using technical expert panel or other stakeholder feedback mechanisms would allow CMS to be best able to make an appropriate decision whether the PHE waiver data should be included or excluded from any future revisions to the NTA component Conditions and Extensive Services item list.

<u>Change 3</u>: Updating the methodology to only utilize SNF Part A claims and the MDS, and not claim types from other Medicare settings (that were used as a proxy to develop PDPM).

AHCA Comment

- **AHCA agrees in part with this approach, but suggests modifications to address conditions not currently required for PDPM resident classification.**

We agree that for those <u>current</u> item rows of 49 PDPM conditions and extensive services used for NTA classification may be appropriate to base future NTA component adjustments on available historical SNF MDS and claim reporting rather than derived estimates using other administrative data. We agree that it was important and valuable for CMS to initially develop and estimate the NTA component to fill in the gaps for data not previously required to be submitted by SNFs, based on using the data from other patient medical claims to identify the presence of condition categories from the Medicare Part C and Part D risk adjustment models (CCs and RxCCs) to predict PDPM coding patterns for new MDS items and ICD-10 diagnosis codes not previously required for payment purposes.

However, we disagree that using SNF MDS and claims exclusively in the future would more accurately reflect the potential coding of conditions and extensive services not currently required to be reported, or that are new emergent conditions or services that were not contemplated for MDS or claim coding purposes. In such cases, CMS should retain its full

arsenal of analytic options, including using CCs and RxCCs or other potentially meaningful data sources. Without these options, CMS will not have the necessary tools to adequately and pay for NTA costs unless the item or service is already required to be reported for payment purposes.

For example, SNF MDS reporting requirements limit the total number of ICD-10 codes that can be entered onto the I8000 A-J data fields. Therefore, coding priorities are to first report those active conditions that directly impact payment in the available fields as the PDPM grouper only relies on diagnoses codes entered onto the MDS. The only claim diagnosis that impacts SNF PPS payment is for HIV/AIDS. Therefore, it does not make sense to base future NTA component risk adjustment solely on diagnoses entered on the MDS or claims. If there are emergent diagnoses such as COVID-19, or new but costly pharmacologic or technology or other treatment innovations for conditions or extensive services not currently reportable on the MDS or required to be reported that require high cost NTAs, CMS should not rely solely on historical SNF MDS or claims trends. If other CMS administrative data such as CCs and RxCCs (or drug cost tables such as COVID-19 therapeutics discussed above) can be used as a proxy to add a new MDS item or diagnosis to the PDPM NTA table, and to estimate their NTA point values, then they should be used, just as they were used during the initial development of the PDPM payment model as described in the April 2018 PDPM Technical Report.

Another example of where the contemplated CMS methodology to exclusively rely on historical SNF MDS and claims reporting to update the NTA component is that the approach would not be able to adapt to increased NTA costs associated with CMS unfunded mandates that impact specific conditions or special services associated with the NTA component. For example**,** CMS recently issued QSO-24-08-NH - Enhanced Barrier Precautions (EBP) in Nursing Homes to mitigate the risk of multidrug-resistant organism (MDRO) transmission that will increase direct care NTA costs for specific residents that meet specific diagnostic and extensive services NTA needs. These patient-specific intervention EBP requirements are not analogous to the infection control practices required during the COVID-19 PHE that CMS considered to be ubiquitous and not resident-specific.

What is most concerning is that most of the residents that would be subject to additional NTA costs related to this new CMS requirement, effective April 1, 2024, would be reimbursed at a lower level than present if the CMS approach suggested in the RFI were adopted. There could be negative unintended consequences for provider access to such levels of care needs if providers can no longer afford to take care of residents with such needs if payments are arbitrarily dropped without considering additional unfunded regulatory requirement costs. Below are just a few examples of the negative impacts on residents if the costs of the new EBPs are not incorporated through an appropriate NTA pricing proxy worked out with stakeholders:

- EBPs costs apply to residents who have a major NTA device (IV medication, parenteral/IV feeding, ventilator intermittent catheterization) most which CMS suggests reducing payments for.
- CMS is suggesting the removal of NTA medical devices that now require the additional cost of PPE under EBP (i.e., tracheostomy, feeding tube, and ostomy).
- EBP costs apply to residents who have other NTA devices such as indwelling catheters or a hemodialysis port.

- EBP also applies to multiple types of NTA wound categories, some which CMS suggests reducing payments for.
- The current MDRO NTA condition item's OLS estimate value has dropped precipitously for unexplained reasons from its current $12.19 to $4.57 in Table 27 of the proposed rule despite also being subject to the new EBP policy requirements.

<u>Change 4</u>: Modifying the overlap methodology to rely more upon the MDS items that use a checkbox to record the presence of conditions and extensive services whenever possible, while allowing for potentially more severe or specific diagnoses to be indicated on MDS item I8000 when it would be useful for more accurate patient classification under PDPM.

AHCA Comment

- **AHCA agrees with the concept of relying more upon MDS checkbox to report conditions and extensive services whenever possible,**
- **It is unclear to AHCA how CMS would operationally allow for more severe or specific diagnoses to be indicated on MDS item I8000 fields to permit more accurate NTA classification.**

We support this concept to rely more on MDS checkbox items to report conditions and extensive services whenever possible. Unlike acute care hospitals, who need more precision in diagnosis reporting to provide services for medical stabilization or surgical procedures, the SNF Medicare population is generally medically stable upon admission, and the focus of post-acute care is to provide for any ongoing skilled nursing care needs, and/or to provide post-acute skilled rehabilitation services to restore or maintain function. The use of checkbox diagnostic and service coding on the MDS usually provides most of the detail necessary to establish that the resident requires a SNF level of care and for case-mix payment determination purposes with the least amount of administrative coding burden. Using specific ICD-10 codes for additional patient case-mix classification refinement, as necessary, rather than as a primary driver of SNF payment seems rational.

However, it is unclear from the RFI description how CMS would propose to operationalize the concept of allowing SNFs to report more severe or specific diagnoses on the MDS I8000 fields, and how the NTA conditions and extensive services point assignment tables would be adapted to include a potentially hierarchical assignment of points per condition, what MDS guidance would be needed for providers to understand when a checkbox item is sufficient, or if a specific ICD-10 code needs to be entered into one of the I8000 MDS item fields to better reflect care needs. We welcome further CMS discussions with stakeholders and via technical expert panels to find a viable pathway to make this concept happen.

<u>Change 5</u>: Prioritizing the reporting of conditions on the MDS by raising the cost threshold for selecting the overlapping CC or Rx CC definitions from any additional cost to five dollars in average NTA cost per day, which is the amount generally associated with a one-point NTA increase.

AHCA Comments:

- **AHCA does not support a fixed $5 threshold to trigger using an overlapping CC or RxCC cost estimate over a MDS cost estimate to increase a NTA item point value by 1 point.**

At first glance, the concept offered by CMS in the RFI seems somewhat reasonable as the CC or RxCC derived costs likely have a larger range for error than the MDS derived cost estimates. However, when we reviewed the April 2018 PDPM Technical Report and the RFI Table 27 data, it appeared that the OLS dollar values between the lowest 2-point NTA item and several of the highest 1-point NTA items were less than $2. Given the potential negative impact for an inaccurate MDS derived cost estimate in these borderline situations, we believe CMS should consider including an additional layer of analysis so instead of only requiring a full $5 difference between the MDS and CC/RxCC derived estimates, the estimates could be blended for just the borderline items.

If this blended cost raises the NTA OLS dollar value above the threshold to obtain the additional NTA point value, then that should occur. For example, in Table 27 of the RFI, the Transfusion Post-admit Code valued at 1 NTA point is only valued 98 cents lower than the 2-pont Diabetes Mellitus Code. Under the current CMS requirement for a minimum $5 difference in price estimate, the Transfusion code CC/RxCC cost estimate would need to be higher than nearly all of the NTA items valued at 2 points to have its point value increased from 1 to 2. We do not believe this is flexible enough. We believe our suggested mitigation approach would reduce the risk that NTA items with MDS estimate costs near the next point threshold may be undervalued.

III. Skilled Nursing Facility Quality Reporting Program (SNF QRP) (89 FR 23461)

The SNF QRP primarily applies to post-acute patients and is part of the IMPACT Act requirements for standardized measures across post-acute providers. However, some measures such as vaccine reporting include other individuals. The SNF QRP levies a two-percentage point reduction in a provider's annual Medicare Part A payment update for SNFs that do not meet reporting requirements. CMS proposes the following changes to the SNF QRP program.

III.A. Proposal to Collect Four New Items as Standardized Patient Assessment Data Elements Beginning with the FY27 SNF QRP (89 FR 23464)

CMS is proposing to require SNFs to report the following four new items as standardized patient assessment data elements on the MDS under the social determinants of health (SDOH) category:

- one item for Living Situation
- two items for Food
- one item for Utilities

Living Situation

The proposed Living Situation item asks: *What is your living situation today?*

The proposed response options are: (0) I have a steady place to live; (1) I have a place to live today, but I am worried about losing it in the future; (2) I do not have a steady place to live; (7) Resident declines to respond; and (8) Resident unable to respond.

Food

The first proposed Food item states: *Within the past 12 months, you worried that your food would run out before you got money to buy more.*

The second proposed Food item states: *Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.*

CMS proposes the same response options for both items: (0) Often true; (1) Sometimes true; (2) Never True; (7) Resident to declines to respond; and (8) Resident unable to respond.

Utilities

The proposed Utilities item asks: *In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?*

The proposed response options are: (0) Yes; (1) No; (2) Already shut off; (7) Resident declines to respond; and (8) Resident unable to respond.

AHCA Comments:

- **AHCA conditionally supports the adoption of three of the four proposed new SDOH items with slight revisions.**

As we have commented in the past, a beneficiary's SDOH risk factors are often key factors influencing the short stay plan of care, the duration of the stay, and whether a discharge to community is successful. We agree with CMS that risk factors such as a person's living situation in the community, and access to adequate nutrition and utilities necessary for a safe and health promoting environment need to be identified and addressed in the plan of care, including discharge planning as feasible. Ultimately, reducing housing, food, utility, and transportation security barriers as part of discharge planning processes can reduce the risk for negative outcomes post return to the community such as hospital readmissions, readmission to the nursing facility for long-term care, and others.

Regarding the four proposed new SDOH items, we support the content and response options of questions with revisions.

It is unclear to us as to why there are two quite similar "Food" items being proposed. CMS did not discuss why each item was insufficient standing alone to identify a food insecurity risk factor or why the Agency felt compelled to propose two separate but similar questions. We are concerned that beneficiaries, who may already be embarrassed to share such personal information related to food insecurity, may be reluctant to respond to, or even become annoyed by having to respond to two nearly identical questions. Additionally, we are concerned that the provider burden of collecting the additional food insecurity response needs to be considered as well. **We urge CMS to adopt one of the two Food items, unless it demonstrates that both items together significantly improve the identification of food insecurity.** Additionally, we

are concerned regarding the paucity of supporting evidence for the proposed food insecurity items and request CMS provide more detailed supporting evidence, or to retract the item pending further evidence. Specifically, the proposed 2-question screen was based on a research study for families with young children (0 – 3 years). We did not see a reference on the MDS item mock-up to another study to support its use in the older population.

Additionally, we ask CMS to consider adding response options to SDOH items to address other situations that may impact care planning. First, the response options do not consider those beneficiaries who reside as long-term care residents with no plans to discharge back to the community. We ask CMS to add a response option or coding criteria that includes those who have resided in the nursing home during the 12-month look-back period. Second, we ask CMS to consider adding a response option for SDOH items that beneficiaries refuse to answer as these refusals are often due to concerns about confidentiality or embarrassment. Considering other provider settings such as ESRD include such an opt out option, adding a beneficiary refused item response would be consistent with the CMS *"Universal Foundation"* of quality measures.

Finally, we ask CMS to provide assurances that providers be offered significant flexibility in how such SDOH item responses are captured and supported. Elsewhere in the SNF QRP RFI section of this proposed rule, CMS discusses how the recent Post-Acute Care (PAC) and Hospice Quality Reporting Program Cross-Setting TEP emphasized the importance of aligning the PAC and hospice quality measures with the CMS *"Universal Foundation"* of quality measures. Such alignment could mean that stable and standardized beneficiary SDOH information could be collected by any one of several different providers and shared at transitions of care. Additionally, many provider pre-admission processes now involve patients filling out pre-admission questionnaires via paper, mobile apps, or patient portals that could serve as the data collection point for such stable SDOH items.

If these SDOH items are adopted, we request that CMS provide guidance that permits a provider to use SDOH item responses gathered through an interview, paper, or electronic survey tool, or received during a transition of care from the immediately preceding provider. We do not believe that post-acute patients want to be burdened with constantly being asked a growing list of the same SDOH questions as they transition through different providers, and having the questions be asked only via an interview such as for MDS reporting purposes when the identical information can be obtained otherwise. If the purpose of the SDOH items is to flag potential follow-up care planning and discharge planning activities, the emphasis should be placed on what was done with the information, however it was obtained, versus how it was obtained.

We believe that documented support of such SDOH questionnaire responses obtained from available sources that were completed by the patient within 30 days prior to the SNF admission is sufficient to help identify housing, food, utilities, or transportation security risks that should be considered during care planning and discharge planning processes.

III.B. Proposal to Modify the Transportation Item Beginning with the FY27 SNF QRP (89 FR 23467)

CMS is proposing to modify the A1250 Transportation SDOH item currently collected in the SNF MDS in two ways: (1) revise the look-back period for when the resident experienced lack of reliable transportation; and (2) simplify the response options.

First, the proposed modification of the Transportation item would use a defined 12-month look back period, while the current Transportation item uses a look back period of six to 12 months.

Second, the proposed modified Transportation item would collect information on whether a lack of reliable transportation has kept the resident from medical appointments, meetings, work or from getting things needed for daily living, rather than collecting the information separately.

The proposed Transportation item asks: *In the past 12 months, has a lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?*

> The proposed response options are: (0) Yes; (1) No; (7) Resident declines to respond; and (8) Resident unable to respond.

AHCA Comments:

- **AHCA supports the modifications of the Transportation SDOH item with revision.**

We appreciate that CMS has reviewed the adequacy of the current SDOH Transportation item and is proposing to modify it so that it simplifies the lookback period to be one consistent date range, simplifies the response items, and aligns with a Transportation item collected on the AHC HRSN Screening Tool, one of the potential tools the IPFQR and Hospital IQR Programs may select for data collection.

Also, since the Transportation item is also an SDOH item, we request that CMS apply the same flexibilities to the Transportation item that we requested for the proposed living situation, food, and utilities security items discussed above. **Specifically, we requested that CMS provide guidance that permits a provider to use SDOH item responses gathered through an interview, paper, or electronic survey tool, or received during a transition of care from the immediately preceding provider.**

We also request that CMS include an "opt out" item response as discussed in the prior section related to the proposed new SDOH items.

III.C. Form, Manner, and Timing of Data Submission under the SNF QRP (89 FR 23468)

III.C.1. Proposed Reporting Schedule for the Proposed New Standardized Patient Assessment Data Elements, and the Modified Transportation Data Element, Beginning October 1, 2025 for the FY 2027 SNF QRP (89 FR 23468)

CMS is proposing that:

- SNFs would be required to report the four new items discussed above as standardized patient assessment data elements under the SDOH category (one Living Situation item, two Food items, and one Utilities item) and the modified Transportation item using the MDS beginning with residents admitted on October 1, 2025 through December 31, 2025 for purposes of the FY 2027 SNF QRP. Starting in CY 2026, SNFs would be required to submit data for the entire calendar year for each program year.
- SNFs that submit the Living Situation, Food, and Utilities items proposed for adoption as standardized patient assessment data elements under the SDOH category with respect to

admission only would be deemed to have submitted those items with respect to both admission and discharge, and
- SNFs collect and submit the proposed modified standardized patient assessment data element, Transportation, at admission only.

AHCA Comments:

- **AHCA supports the CMS proposal to require any new SDOH items adopted in the final rule related to Living Situation, Food, or Utilities security to be reported on the MDS beginning with residents admitted on October 1, 2025 through December 31, 2025 for purposes of the FY 2027 SNF QRP, and for the entire calendar year for subsequent program years.**
- **AHCA supports the CMS proposals for providers to submit the new and revised SDOH items adopted in the final rule to only be required on admission.**

We agree with CMS that the SDOH information items discussed in this proposed rule reflect housing, food, utilities, and transportation security issues that are likely relatively stable during the SNF stay. This was confirmed by the CMS internal analysis of the transportation item discussion in the proposed rule having less than 1 percent change in the item response between admission and discharge. Thus, we appreciate the CMS proposal to reduce provider burden by eliminating the Transportation item form the discharge assessment, and by consistently applying the new proposed SDOH items to only be reported at admission. As we have discussed above, we contend that the item response is also likely to be stable within the 30 days prior to the SNF admission.

Finally, as discussed above, we recommend that unless CMS can demonstrate that both proposed Food SDOH items together significantly improve the identification of food insecurity, we believe only the item with the better performance be adopted and included in these reporting requirements.

III .D. Proposal to Participate in a Validation Process Beginning with the FY27 SNF QRP (89 FR 23469)

III .D.1. Proposal To Participate in a Validation Process for Assessment-Based Measures (89 FR 23469)

The Consolidated Appropriations Act (CAA) of 2021 (Pub. L. 116–260)) requires the Secretary to apply a process to validate data submitted under the SNF QRP. CMS is proposing to amend the regulation text at 42 CFR § 413.360 to require SNFs to participate in a validation process like the existing SNF VBP validation process that would apply to data submitted using the MDS and SNF Medicare fee-for-service claims as a SNF QRP requirement beginning with the FY27 SNF QRP. Details include:

- A validation contractor would select, on an annual basis, up to 1,500 SNFs that submit at least one MDS record in the CY three years prior to the applicable FY SNF QRP.
- The SNFs that are selected to participate in the SNF QRP validation for a program year would be the same SNFs that are randomly selected to participate in the SNF VBP validation process for the corresponding SNF VBP program year.

- Each SNF selected would only be required to submit records once in a FY, for a maximum of 10 records for each SNF selected.
- The selected SNFs would have the option to submit digital or paper copies of the requested medical records to the validation contractor and would be required to submit the medical records within 45 days of the date of the request.
- If a SNF does not submit the requested number of medical records within 45 days of the initial request, CMS would reduce the SNF's otherwise applicable annual market basket percentage update by two percent. The reduction would be applied to the payment update two FYs after the FY for which the validation contractor requested records.

CMS intends to propose, in future rulemaking, the process by which the agency would evaluate the submitted medical records against the MDS to determine the accuracy of the MDS data that the SNF reported, and that CMS used to calculate the measured results.

CMS is also considering additional validation methods that may be appropriate to include in the future for the current measures submitted through the National Healthcare Safety Network (NHSN), as well as for other new measures it may consider for the program to be addressed through separate and future notice-and-comment rulemaking, as necessary.

AHCA Comments:

- **AHCA generally supports the proposed process for implementing the Consolidated Appropriations Act requirements for MDS-based SNF QRP validation process pending some adjustments.**
- **AHCA requests that CMS resolve conflicts between the performance period dates and measure specifications proposed for the SNF QRP and VBP validation to assure intended minimization of provider burden.**
- **AHCA requests that validation contractors be adequately educated about the MDS coding and measure specification requirements and that there is an opportunity to correct and/or appeal a contractor's decision in a streamlined manner.**
- **AHCA recommends engagement with stakeholders prior to future rulemaking to address concerns about potential approaches at determining the accuracy of the MDS assessments to calculate future measure results.**
- **AHCA recommends engagement with stakeholders prior to future rulemaking to address concerns about potential validation approaches for NHSN-based measures.**

We appreciate that CMS has proposed a process to comply with the CAA for SNF QRP purposes that appears to limit the amount of new burden on the 1,500 providers selected each year. The SNF QRP adjustment would be associated with the submission of the requested supporting documentation, not the accuracy of the assessments at this time. By aligning the SNF QRP reporting requirements to mirror the existing SNF VBP validation requirements, no additional providers would be required to submit QRP validation supporting documentation beyond those 1,500 already required to submit assessments for VBP validation, as the selected assessments would be used by CMS for both purposes. There may be an additional burden associated with submitting SNF QRP item supporting documentation that may be above and beyond that needed for VBP validation purposes. The primary additional risk for providers not submitting the additional requested SNF QRP item documentation in addition to that required for VBP validation purposes is that, in addition to any SNF VBP penalties, the provider would also be

subject to the separate SNF QRP two percent payment adjustment in a subsequent year for noncompliance.

However, before finalizing this proposal we request that CMS resolve the apparent misalignment between the performance periods and measure specifications between the two programs and the measures to be validated. For example:

- The SNF QRP FY 2027 is proposed to use data from calendar year 2024 while the SNF VBP FY 2027 uses baseline data from fiscal year 2023 and performance data from fiscal year 2025.
- The fall measures are not aligned, and it is unlikely the same MDS records would be requested for validation for both the SNF QRP and SNF VBP.
    - The SNF VBP uses the MDS-based measure, Percent of residents experiencing one or more falls with major injury (Long stay). This measure includes only long-stay nursing home residents with 101 or more cumulative days in the facility.
    - The SNF QRP uses the MDS-based measure, Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long stay). This measure reports the percentage of Medicare Part A SNF stays during which one or more falls with major injury were reported during the SNF stay.

Regarding future considerations of the process by which the agency would evaluate the submitted medical records against the MDS to determine the accuracy of the MDS data that the SNF reported, and that CMS used to calculate the measured results, we urge the Agency to engage with SNF stakeholders, including hosting technical expert panels. When the MDS assessment was initially developed it was intended to be a source record, particularly related to interview questions. There was no need to also document elsewhere in the medical record redundant assessment information. However, as the MDS has also become a tool for reimbursement purposes, payment auditors have penalized providers for not having such redundant and burdensome documentation also repeated elsewhere in the medical record. Additionally, many states also have their own documentation requirements in addition to, and sometimes contrasting with, those published in the MDS-RAI manual which further complicates any potential SNF QRP assessment validation audit process.

We contend that the MDS is part of the medical record and while some items may require more detail to be included elsewhere in the medical record so that appropriate care can be provided and progress measured, not all items do. We are concerned that if CMS establishes an arbitrary minimum MDS "accuracy" threshold as part of the SNF QRP validation process in the future without first establishing clear guidelines understood by both the providers and the SNF QRP validation contractors regarding support documentation requirements for each SNF QRP assessment-based element, there could be severe variation in the performance scores of providers dependent upon the knowledge and accuracy of the SNF QRP validation contractor's determination rather than on whether the MDS was accurately completed.

We are concerned that the selected validation contractors will not be adequately prepared to complete the reviews accurately. Implementation for the FY 2027 program year (discussed above) does not allow time for future rulemaking to determine *"the process by which [CMS] would evaluate the submitted medical records against the MDS to determine the accuracy of the MDS data that the SNF reported, and that CMS used to calculate the measure results."* SNF

providers have and are facing challenges with newly established contractor review staff misunderstanding of the MDS manual coding guidance. For example, the SNF 5-Claim Probe and Educate Review process rapidly established within the past year, resulted in inappropriate error decisions that resulted in negative payment implications or forced providers to complete burdensome audit appeal processes to resolve. CMS should apply lessons-learned from that process to better assure that providers and validation contractors clearly understand the validation process requirements, including an opportunity to correct and/or appeal a contractor's decision in a streamlined manner any future performance-based SNF QRP validation-based measure as there are payment adjustment implications.

Additionally, given that a given randomly selected provider may be required to submit documentation to support from one to a maximum ten assessments per year, the risk of possibly dropping below an arbitrary "accuracy" threshold and be subject to a two percent payment adjustment in a subsequent year would increase exponentially with any errors found as the number of assessments and supporting documentation requested get closer to one. This barrier alone would be extremely difficult to overcome in a fair manner.

Finally, as CMS contemplates potential future additional SNF QRP validation approaches related to data submitted through NHSN, we again urge the Agency to engage with SNF stakeholders, including hosting technical expert panels. The primary purpose of NHSN data submission is for public health surveillance and infection control purposes such as vaccine uptake reporting. There have been multiple challenges for providers over the years with both the data submission processes to NHSN as well as data coordination between the Centers for Disease Control (CDC) that manages NHSN reporting processes, and CMS who manages the SNF QRP requirements. These additional layers of complexity multiply the challenges that need to be considered above and beyond those that we have discussed above related to validating the accuracy of MDS assessment-based data.

III.D.2. Proposal to Apply the Existing Validation Process for Claims-Based Measures Reported in the SNF QRP (89 FR 23469)

Beginning with FY27 SNF QRP, CMS is proposing to apply the process the agency currently uses to ensure the accuracy of the Medicare fee-for-service claims to validate claims-based measures under the SNF QRP.

AHCA Comments:

- **AHCA strongly opposes the current CMS proposal to apply existing Medicare fee-for-service contractor processes to comply with the Consolidated Appropriations Act requirements for SNF QRP validation purposes.**
- **AHCA recommends that CMS not finalize this proposal and meet with stakeholders prior to future rulemaking to identify a more appropriate approach to be presented in subsequent rulemaking.**

Our first concern about this proposal is that it is vague and provides insufficient detail to estimate what the scope and burden would be associated with this proposal. Unlike the abovementioned SNF QRP MDS assessment validation process that clearly identifies how many providers would be impacted per year (1,500), clearly identifies limits to how many assessments would need documentation submitted for per year (up to 10) and is linked to SNF VBP validation reporting

assessments to minimize documentation burden, this proposed claim-based validation process offers no parameters of the size and scope of the process. Instead, CMS vaguely references that… *"We believe that adopting the MAC's existing process of validating claims for medical necessity through targeted and random audits would satisfy the statutory requirement to adopt a validation process for data submitted under the SNF QRP for claims-based measures…"* We offer the following questions that directly impact the size and scope and resultant provider burden:

1. How many SNF providers would be subject to the proposed claims-based SNF QRP validation process?
2. Is there a limit to the number of proposed claims that a provider must submit supporting documentation to the MAC for claims-based SNF QRP validation process?
3. Why are the providers selected for the MDS assessment-based proposed SNF QRP validation process proposed to be selected randomly each year in alignment with the SNF VBP validation process while the proposed claims-based SNF QRP validation process to be selected via both "targeted and random audits"?
4. Please explain what the specific criteria would be for these fee-for-service payment contractors to "validate" the accuracy of the SNF quality-related data so a provider would not be subject to a two percent SNF QRP adjustment in a subsequent year?
5. Please explain exactly how a fee-for-service payment auditor would convert/apply their payment process to *"…use software to determine whether billed services are medically necessary and should be covered by Medicare, review claims to identify any ambiguities or irregularities, and use a quality assurance process to help ensure quality and consistency in claim review and processing."* in order to validate a claims-based SNF QRP measure?
6. Should providers submit supporting documentation specific to the claims-based quality measures, and if so, what specific documentation is that? Or are providers submitting data supporting SNF QRP measures to assume that the MACs will also be auditing the same claims for payment audit purposes?

As we discussed in the prior section, we are concerned that if CMS establishes an arbitrary minimum "accuracy" threshold as part of the SNF QRP validation process without first establishing clear guidelines understood by both the providers and the SNF QRP claims-based validation contractors regarding support documentation requirements for each SNF QRP claims-based element, there could be severe variation in the performance scores of providers dependent upon the knowledge and accuracy of the SNF QRP MAC validation contractor's determination rather than on whether the claim was accurately completed for this purpose.

Given the fact that CMS is proposing this process to apply the claims-based process to impact the FY27 SNF QRP and put providers at risk for a two percent payment adjustment with no clear description of what the proposed "process" will be, it is imperative that CMS not finalize this proposal and meet with stakeholders to identify a more appropriate approach to be presented in subsequent rulemaking.

III.E. Proposal to Amend the Regulation Text at § 413.360 (89 FR 23469)

CMS proposes to amend the regulatory text at § 413.360 to implement the above-proposed SNF QRP assessment-based and claims-based validation processes.

AHCA Comments:

- **AHCA requests that CMS revise the proposed changes at the regulatory text at § 413.360 due to above request to not finalize the proposed claims-based process and an apparent technical error.**
- **AHCA requests that CMS not finalize the proposed paragraph § 413.360(g)(2) regulatory language pending further consideration as we have discussed in our detailed comments above.**

Specifically, we note that on (89 FR 23494 column 2) it appears that the proposed paragraph § 413.360(g)(1)(iii) may be misworded. This paragraph is contained under the description of MDS-assessment-based SNF QRP validation process requirement to submit supporting medical records documentation within 45 days of the date of the records request but does not reference the MDS-based validation process paragraph (g)(1) and instead references paragraph (g)(2) which is related to the claims-based SNF QRP validation process. We have three concerns here:

First, the specific MDS-based SNF QRP validation process discussed in the proposed rule specifically details the 45-day documentation response time, while the apparent omission of the reference to paragraph (g)(1) in the proposed new § 413.360 language would leave this response time requirement in regulatory limbo. We believe the reference should be to paragraph (g)(1).

Second, as we have commented on earlier, the specific claims-based SNF QRP validation process discussed in the proposed rule does not provide any detail of the intended process for how the claims-based validation process would be conducted, and the proposed new § 413.360(g)(2) regulatory language similarly contains no such detail. As such we believe the apparently erroneous reference to paragraph (g)(2) noted above should be removed.

Finally, as discussed in detail in our earlier comments, we believe that paragraph (g)(2) should be rescinded from the proposed § 413.360 revisions pending further consideration for reintroduction in a revised manner in future rulemaking.

III.F. SNF QRP Quality Measure Concepts under Consideration for Future Years – Request for Information (RFI) (89 FR 23468)

CMS is seeking input on the importance, relevance, appropriateness, and applicability of each of the concepts under consideration listed in Table 29 of the proposed rule for future years in the SNF QRP.

AHCA Comments:

We appreciate the opportunity to provide ongoing feedback on the four future measure concepts under consideration for the SNF QRP and that CMS has taken prior feedback and has convened technical expert panels to consider next steps. This is particularly important as SNF and other post-acute providers are now included in the CMS intention to align post-acute care and hospice measures with CMS' Universal Foundation of quality measures. We agree with CMS that the Universal Foundation aims to focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for comparisons across programs, and help identify measurement gaps is a desirable objective. Such an approach should help providers across all settings coordinate care and improve outcomes.

An added benefit would be to align core data elements as feasible to facilitate improvements in interoperable healthcare technology standards and adoption. As SNF and other post-acute providers were excluded from the HITECH incentive program intended to optimize the adoption of interoperable technology, any administrative efforts by CMS to reduce the data specification barriers related to quality data would help reduce the burden and costs of adopting such technology capabilities. Below we offer our comments associated with the four measure concepts under consideration.

III.F.1. Vaccination Composite Measure Concept

- **AHCA strongly encourages CMS to explore the benefits of a potential future Vaccination Composite Measure**.

As was emphasized during the COVID-19 pandemic, vaccines may not only help prevent illness, or minimize symptoms, but they save lives. This is particularly true for key conditions including COVID-19, influenza, respiratory syncytial virus (RSV), and pneumonia that have the most severe impact on those older adults and individuals with multiple chronic conditions that receive post-acute or long-term care in nursing homes. Reporting of vaccination uptake provides valuable public health information that can be used for multiple purposes related to surveillance, identifying disease risk mitigation priorities, and responding to outbreaks.

However, such reporting of vaccination status for short- and long-stay residents and staff of nursing facilities can be challenging and burdensome, and these factors increase with the number of different vaccine measures and reporting requirements that may change over time in response to emerging viral trends. Currently SNFs are required to report certain vaccination data to the Centers for Disease Control (CDC) who then shares such information with CMS, as well as being required to submit resident vaccination status data on the MDS assessment for SNF QRP purposes.

The thoughtful development of a single composite measure, especially one that could leverage more automated interoperable healthcare technology reporting processes, may help to achieve the quality objectives for the reporting of certain vaccination status information while reducing the provider burden associated with reporting and review and correct processes within the SNF QRP program.

III.F.2. Pain Management Measure Concept

- **AHCA supports efforts to develop a meaningful pain management measure or measures for short- and long-stay populations and look forward to seeing whether the data from the recently implemented MDS item in Section J0300-J0600 that assesses pain interference with (1) daily activities, (2) sleep, and (3) participation in therapy could provide a foundation for future proposed measures.**
- **AHCA does not believe it is appropriate at this time to consider developing condition-specific subgroup measures of existing measures such as discharge function due to concerns about facility-specific sample limitations and measure stability, although analysis of differences at a more aggregated level may be informative for identifying potential benchmarks and best practices.**

In prior RFI's, CMS indicates that despite the prevalence of chronic conditions and need for pain management in nursing facilities, existing SNF QRP measures do not directly address aspects of care rendered to populations with chronic conditions or SNFs' management of residents' pain. Beginning October 1, 2023, SNFs began collecting new standardized resident assessment data elements, including items in Section J0300-J0600 that assess pain interference with (1) daily activities, (2) sleep, and (3) participation in therapy, providing an opportunity to develop more-concise measures of provider performance. At the time CMS was seeking input on measures of chronic condition and pain management that may be used to assess SNF performance.

Additionally, the Agency sought general comment on the feasibility and challenges of measuring and reporting SNF performance on existing QRP measures, such as the Discharge Self-Care Score for Medical Rehabilitation Patients and Discharge Mobility Score for Medical Rehabilitation Patients measures, for subgroups of residents defined by type of chronic condition. As examples, measures could assess discharge outcomes for SNF residents with a hip fracture diagnosis or for residents admitted with a diagnosis of congestive heart failure.

Pain management is a critically important care issue in the short- and long-stay nursing home population as appropriate management has shown to reduce resident stress/anxiety, improve outlook, and improve functional outcomes. Effective pain management requires a balance between medication management, environmental, and behavioral approaches in the care planning process. Proper assessment of pain, particularly how it impacts key areas such as daily activities, sleep, and participation in therapy (when applicable) is an essential first step in developing a meaningful measure.

Using pain management as a potential future SNF QRP quality measure does pose risks for unintended consequences. In the past, CMS previously used pain measures for the NHQI and Five-Star, but removed them in 2019 citing the following rationale:

> *In March 2019, CMS released the CMS Roadmap for Fighting the Opioid Crisis. One aspect of this roadmap is a directive to address how quality measures may provide incentives for inappropriate opioid prescribing. We believe facilities have taken strong actions to prevent the overuse of opioids. However, due to the severity of the Opioid Crisis, we want to avoid any potential scenario where a facility's performance on the pain quality measures may inappropriately contribute to their decision to seek the administration of an opioid. To support this, CMS will be removing two quality measures from the Nursing Home Compare website and the Five Star Quality Rating System in October 2019. These measures are:*
>
> - *Percentage of short-stay residents who report moderate to severe pain.*
> - *Percentage of long-stay residents who report moderate to severe pain.*

However, we are hopeful that the recently implemented MDS items in Section J0300-J0600 related to pain assessment beginning in October 2023 may provide a foundation for an effective future pain management measure if it can overcome the potential to incentivize inappropriate use of pain medication. One of the largest challenges in the nursing facility environment is the high proportion of residents with cognitive deficits that result in an inability to effectively verbalize pain responses, but instead may convey pain in other ways including gestures, vocalizations, or atypical behaviors. We ask CMS to carefully consider these issues as future pain management measures are contemplated.

With regards to the earlier CMS discussion about considering the feasibility and challenges of measuring and reporting SNF performance on existing QRP measures, such as the Discharge Self-Care Score for Medical Rehabilitation Patients and Discharge Mobility Score for Medical Rehabilitation Patients measures, for subgroups of residents defined by type of chronic condition, we do not believe it is feasible or necessarily appropriate to develop facility-specific short-term outcomes measures of such granularity at this time.

First, by the very nature of the SNF Part A benefit, Medicare beneficiaries are typically not admitted to a SNF to manage a chronic condition, but to provide care related to a recent significant change in health/functional status the now requires a SNF level of care to resolve. While it may be true that persons admitted to SNF commonly also have multiple chronic conditions that impact the rate of recovery, the chronic conditions in themselves are not typically the primary reason for the SNF stay. This issue itself could lead to significant attribution challenges for such granular subgroup measures.

Second, many SNFs have fewer than 100 Medicare admissions per year across multiple conditions Although CMS was able to develop statistically stable and effective risk-adjusted functional outcomes measures across all conditions with a minimal number of facilities being excluded due to an insufficient Medicare population, it seems much more likely that the statistical performance of subgroup measures by chronic condition category would be much less stable, and a much larger proportion of providers would need to be excluded from the subgroup measure. We do not see the utility of developing a subgroup measure that only compares the performance of high-volume providers.

Finally, current risk-adjusted outcomes measures including functional measures, by the definition of risk-adjustment, already account for all acute and comorbid conditions that contribute to the expected outcomes performance. We have concerns that if subgroups of conditions receive special attention by establishing a separate outcomes measure, it could result in unintended consequences of care disparities for residents with conditions not receiving such special measure attention.

While we are concerned about the feasibility or appropriateness of developing facility-specific outcomes subgroup measures for persons with specific chronic conditions, we do believe there is utility in CMS conducting and sharing analysis of differences in outcomes by condition subgroups at a more aggregated level, as such information may be informative for identifying potential benchmarks and best practices.

III.F.3. Depression Measure Concept

- **AHCA supports the concept of developing a Depression related quality measure, but much work is needed to identify the importance, relevance, appropriateness, feasibility, and applicability of such a measure or measures.**

The complexity of myriad approaches at labeling the term “depression,” how interventions are applied, and what possible outcomes could be measured that could be used to help improve care quality and outcomes make this concept even harder to get a handle on than the pain management measurement concept discussed above. For example, within a SNF environment, short-stay post-acute admission residents may be experiencing temporary and short-term signs and symptoms of “depression” due to a recent health event that resulted in the post-acute SNF

stay, while long-stay residents may be experiencing chronic "depression" related to organic medical and/or psychological conditions.

A medical diagnosis of depression that meets the ICD-10 diagnosis coding criteria is fairly stringent, relying on medical provider documentation, and not MDS item coding guidance and typically is used to justify a specific clinical or pharmacologic treatment approach. In contrast, the SNF MDS assessment uses a multiple-item Resident Mood Interview (used with residents able to complete an interview) or Staff Assessment of Resident Mood (used with residents unable to complete an interview due to impairments such as cognitive or physical limitations) to identify signs and symptoms that could indicate depression and could trigger referrals to physicians or other mental health professionals as well as triggering the introduction of specific care plan interventions withing the facility.

The two MDS resident mood item sets are screening tools and are not diagnostic, however, the MDS manual guidance for interpreting the Total Severity Score from the two MDS resident mood item sets state that the *"Total Severity Score can be used to track changes in severity over time."* The CMS manual further states that the Total Severity Score for residents showing any signs or symptoms of depression can be interpreted as one of five different levels of severity depending upon point totals above zero including minimal depression, mild depression, moderate depression, moderately severe depression, and severe depression.

In addition to its use to help develop a resident's care plan and for possible quality measure purposes, the MDS resident mood interview total severity score is also used as a case-mix adjuster for Medicare Part A SNF PPS PDPM payment model as well as a case-mix adjuster for Medicaid payment models in many states.

To add to the complexity, on October 1, 2023, the MDS Resident Mood Interview item set was revised from the PHQ-9 version, which required all questions to be answered, to the PHQ-2 to 9 version that only requires questions 3-9 to be answered if both of the first two depression symptom items are marked as present and both have a reported symptom frequency of at least 7 days over the prior two weeks. With the elevated threshold before questions 3-9 can be asked, it is expected that the PHQ-2 to 9 will be less sensitive to capturing signs of symptoms of depression in SNF residents.

From a clinical standpoint this may negatively impact outcomes in several areas if the presence of depression was not identified on the screen and addressed in the care plan. Additionally, the resultant mood interview Total Severity Scores will likely shift lower for some residents as well as with overall averages (suggesting lower presence of depression), making analysis of the presence of depression on the MDS for a possible depression quality measure difficult as the measurement tool was substantively changed for assessments with an assessment reference date starting October 1, 2023.

We also note that the Staff Assessment of Resident Mood PHQ-9-OV item set remains unchanged, and all nine item responses require completion. This further creates differences that would need to be considered if a depression quality measure were developed using both MDS-based resident mood depression screening tools.

Finally, like the potential pain measure concept discussed above, we believe that there could be a risk for unintended consequences of the measure incentivizing overmedication if a depression

measure is poorly designed and incentivizes masking the symptoms versus addressing the underlying physical or mental condition.

Given the above concerns, but recognizing that a potential depression measure cannot be developed without data, we have identified that in a SNF, the prevalence of "depression", could be tracked and measured over time using existing data as part of a potential future depression measure using any of the following data points used in SNFs:

- Claim diagnosis code of depression
- MDS diagnosis code of depression in Section I
- MDS mood interview Total Severity Score in Section D
    - Could be tracked by the multiple levels of severity as discussed above
    - Could be tracked by the SNF PPS PDPM case mix trigger of 10 or more points present on the MDS Mood Interview Total Severity Score (if moderate depression or worse)
- SNF case-mix payment HIPPS code indicating the application of the depression case mix adjustor in the Nursing component (if moderate depression or worse)
    - Could be tracked via the SNF MDS assessment billing HIPPS code in Section Z
    - Could be tracked via the claim HIPPS code

Each of the above approaches has advantages and disadvantages that would need to be considered while contemplating whether they are appropriate for a depression measure. For example, we have observed significant rates of the prevalence of "depression" in residents under a Medicare Part A stay depending on the source data used. In addition to reviewing CMS administrative public use file data, AHCA has been tracking the use of depression diagnosis codes on SNF Part A claims and 5-Day PPS MDS assessments for several years. Here are some observations:

- The CMS Medicare Provider Utilization and Payment Data: Post-Acute Care and Hospice (PAC PUF) files indicate that in both 2020 and 2021, 61 percent of beneficiaries experiencing a SNF Part A stay met the criteria of "depression" as a chronic condition[1].
- AHCA analysis[2] of SNF Part A claims from January 2019 through May 2023 (excluding claims with a COVID-19 ICD-10 diagnosis or COVID-19 waiver claims) show that:
    - The percentage of resident days a depression claim diagnosis has increased from 25 percent to 32 percent, including significant spikes and variability early in the COVID-19 pandemic.
    - The percentage of resident days a Medicare Part A claim HIPPS code containing a Nursing component case mix adjusted group code reflecting the presence of dementia has increased from slightly under 10 percent to about 18 percent, including some variability throughout the COVID-19 pandemic.
- AHCA analysis[2] of SNF Part A MDS 5-day assessments from October 2019 through June 2023 (excluding assessments containing a COVID-19 ICD-10 diagnosis) representing the percentage of Medicare Part A stays that contained 10 or more points present on the MDS Mood Interview Total Severity Score that would trigger the SNF PPS PDPM case mix depression adjustment withing the Nursing component. Of note is that there are significant differences in the trends between the Resident Mood Interview depression

prevalence upon admission and the Staff Assessment of Resident Mood depression prevalence upon admission.

- The Resident Mood Interview PDPM depression score trend has increased steadily from 10 percent to 18 percent.
- In contrast the Staff Assessment of Resident Mood depression score for residents unable to complete the interview stayed relatively stable from a low level of 1.2 percent to 1.6 percent. We also note that the Part A PPS discharge assessment does not require Staff Assessment of Resident Mood item completion.

In summary, as the discussion above highlights, with the significant variability of definitions and reported prevalence of the term "depression" within just the SNF Medicare Part A population data, the small percentage of Part A residents in the overall SNF resident population, and the variability in the trends over time, it behooves CMS to meet with stakeholders via technical expert panels and other methods to discuss the technical challenges and opportunities within the context of what is the desired quality outcome for a quality measure related to factors such as the following (not an exhaustive list):

- What is the impact of "depression" on a nursing facility resident's quality of life and clinical outcomes?
- How could a depression quality measure results be used to help improve care and outcomes?
- What would a specific outcome be that would reflect appropriate quality of care for a person with depression? Reduced depression score? Improved engagement with life activities?
- What population would the depression measure be applicable to? Medicare Part A short-stays? Long-stays? All residents?
- What data sources would be needed for the measure? If new – What additional burden would the resident and provider be subject to?
- Would risk-adjustment be required?
- Would multiple measures be required? For short-stays versus long-stays? For acute depression versus chronic depression? For residents able to complete a mood interview versus those that cannot?
- How would the measure offer protections from incentivizing overmedication?

III.F.4. Patient Experience of Care/Patient Satisfaction Measures Concept

- **AHCA supports the concept of developing a resident experience of care measure, but more work is needed to align with the CMS measures guiding principles.**
- **AHCA has been an ardent supporter of a SNF patient satisfaction measure and continues to support the adoption of the endorsed CoreQ: SS DC measure assesses the level of satisfaction among SNF short-stay residents, but with less burden than previously proposed by CMS.**

CMS defines resident experience measures as those that focus on how residents experienced or perceived selected aspects of their care, whereas resident satisfaction measures focus on whether a resident's expectations were met.

Information on resident experience of care is typically collected via instruments that rely on resident self-reported data. The most prominent among these is the CAHPS suite of surveys. The Nursing Home Discharged Resident CAHPS, which is intended for use with residents who had a length of stay less than 100 days, measures resident experience in terms of the care environment, communication with staff, respect received, quality of care, autonomy, and activities.

More recently, the Moving Forward Coalition has been developing a proposed SNF patient experience measure that may be less burdensome than the CHAPS survey approach.

The CoreQ questionnaires represent resident satisfaction tools. In particular, the CoreQ: SS DC measure meets the critical IMPACT Act requirement as an endorsed measure and assesses the level of satisfaction among SNF short-stay (less than 100 days) residents. CMS previously proposed adopting a modification of the CoreQ: SS DC measure in the FY 2024 SNF PPS proposed rule for the SNF QRP beginning with the FY 2026 SNF QRP but ended up not adopting it. One of the reasons for resistance to the measure as proposed was that the proposed CMS modifications added significant burden and provider cost obligations beyond what was necessary to achieve the endorsed measure's scientifically established performance levels.

In prior RFIs, CMS was seeking comment on the feasibility and challenges of adapting existing resident experience measures or creating new measures for use in the SNF QRP, the challenges of collecting and reporting resident experience and resident satisfaction data, and the extent to which resident experience measures offer SNFs sufficient information to assist in quality improvement. The following comments expand on our prior RFI responses.

As discussed in last year's comment letter response, AHCA has been an ardent supporter of a SNF patient satisfaction measure and continues to support the adoption of the endorsed CoreQ: SS DC measure assesses the level of satisfaction among SNF short-stay residents, but with less burden than previously proposed by CMS.

Regarding the resident experience measure concept, we believe more work is needed in this area to assure that the potential future resident experience measure is actionable, minimizes burden, and improves resident outcomes. It is well established that persons who believe their personal goals, care preferences, and priorities (GPP) are heard and followed-up on by the care team applying a person-centered approach are more likely to participate in their environment, be happier, and have better clinical outcomes.

We fully support further measure development activity, including SNF stakeholder participation in future TEPs to resolve these challenges. We also encourage CMS to look at the activities of the Moving Forward coalition, in particular Committees #1, #6, and #7 that have conducted an environmental scan of potential GPP item sets and measures, and are working to develop a measure that could collect essential patient GPP data with low risk for bias, be incorporated into the facility's care planning process, and be more timely and less burdensome than the CAHPS survey which we believe is excessively burdensome and will not facilitate improved care. AHCA has representatives on several of these Moving Forward Coalition committees working towards developing an appropriate and actionable patient experience measure for nursing home residents, and we look forward to seeing if their efforts' outputs can help CMS identify a potential resident experience measure proposal.

[1] https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-provider-utilization-payment-data/post-acute-care-hospice
[2] Example trend charts containing AHCA analysis of MDS and Claim depression prevalence trends from 2019 through 2023 can be found in the Appendix of these comments.

IV. Proposed Updates to the Skilled Nursing Facility Value-Based Purchasing Program (89 FR 23470)

IV.A. Proposed Regulation Text Technical Updates (89 FR 23470)

CMS is inviting public comment on their proposal to make technical updates to regulation text:

1. CMS is proposing to update the definition of ‘‘SNF readmission measure’’ by:
    a. Replacing the references to the Skilled Nursing Facility Potentially Preventable Readmissions (SNFPPR) measure with a reference to the Skilled Nursing Facility Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure,
    b. Clarifying that both measures are specified under the Act,
    c. Clarifying SNF readmission measure will be SNF WS PPR beginning 10/1/27.
    d. This change would align the definition of ‘SNF readmission measure’ with policies previously finalized for SNF VBP, including that we will replace the SNFRM with the SNF WS PPR beginning October 1, 2027.
2. CMS is proposing to redesignate the term ‘‘performance score’’ at § 413.338(a) with the term ‘‘SNF performance score’’ for consistency with the terminology in use in the Program, and to make conforming edits to the last sentence of § 413.337(f).
3. CMS is proposing to replace references to ‘program year’ with ‘fiscal year’ in the definitions of ‘health equity adjustment (HEA) bonus points,’ ‘measure performance scaler’, ‘top tier performing SNF’, and ‘underserved multiplier’ to align terminology.
4. CMS is also proposing to include additional components of the MDS validation process that was finalized in the FY 2024 SNF PPS final rule. This includes the SNF selection, medical record request, and medical record submission processes for MDS validation. A new paragraph would be added that states the SNF VBP measure set for each year includes the statutorily required SNF readmission measure, and beginning with FY 2026, up to nine additional measures specified by CMS.

AHCA Comments:

- **AHCA continues to not support the MDS audit process for validating MDS-based measures in SNF VBP. There are already extensive MDS-validation processes at the state and federal level. Having another one only for SNF VBP measures is an inefficient use of resources for both providers and auditors. The process also contradicts the rationale used to not add any additional validation steps or audits for any of the claims-based or PBJ-based measures in SNF VBP.**

IV.B. Proposed Measures Selection, Retention, and Removal Policy (89 FR 23471)

CMS is seeking comments on their proposal to adopt the below measure selection, retention, and removal policy beginning with the FY 2026 SNF VBP program year. This proposed policy would

apply to all SNF VBP measures except for the SNF readmission measure because CMS is statutorily required to retain that measure in the measure set.

1. CMS is proposing that when a measure is adopted for the SNF VBP Program for a particular program year, that measure would be automatically retained for all subsequent program years unless it is proposed to remove or replace the measure. This policy would also avoid the need to continuously propose a measure for subsequent program years.
2. CMS is proposing to use notice and comment rulemaking to remove or replace a measure in the SNF VBP Program to allow for public comment.
3. CMS is also proposing to use the following measure removal factors to determine whether a measure should be considered for removal or replacement:
   (1) SNF performance on the measure is so high and unvarying that meaningful distinctions and improvements in performance can no longer be made;

   (2) Performance and improvement on a measure do not result in better resident outcomes

   (3) A measure no longer aligns with current clinical guidelines or practices;

   (4) A more broadly applicable measure for the particular topic is available;

   (5) A measure that is more proximal in time to the desired resident outcomes for the particular topic is available;

   (6) A measure that is more strongly associated with the desired resident outcomes for the particular topic is available;

   (7) The collection or public reporting of a measure leads to negative unintended consequences other than resident harm; and

   (8) The costs associated with a measure outweigh the benefit of its continued use in the Program.

AHCA Comments:

- **AHCA supports the proposed measure selection, retention, and removal policy. The proposed criteria align with measures endorsed by the Partnership for Quality Measurement (PQM), which is a CMS-certified consensus-based entity. Thus, measures not endorsed by PQM should be removed and not eligible for SNF VBP.**

IV.C. Future Measure Considerations (89 FR 23472)

While CMS does not propose any new measures, they welcome continuing feedback on potential new measures topics and other measure set adjustments.

AHCA Comments:

- **AHCA continues to not support the addition of long-stay measures, such as falls and hospitalizations, to Medicare SNF VBP because it does not align with the intent of the VBP program to link Medicare FFS reimbursement with the care and outcomes of Medicare FFS beneficiaries.**
- **AHCA also continues to not support the inclusion of measures that have not been captured or publicly reported for at least three years. New measures, like the Discharge Function Score, take time to understand and establish evidence-based**

practices for improving and maintaining performance. Adjusting reimbursement rates on new measures hinders the ability to do small tests of change and puts pressure to instead make wide-scale change that might not be effective or efficient.

- **AHCA continues to support the adoption of CoreQ to measure resident satisfaction. Residents deserve a direct voice in measuring the value of the care they receive. CoreQ is endorsed by the Partnership for Quality Measurement (PQM) as a valid, reliable, and practical measure to collect.**
- **For the Staff Turnover measure, AHCA recommends revising the specifications to only count gaps in employment of more than 120 days, not 60 days, as turnover.**

Currently, if an eligible employee has a 60-day gap in the calculation period it is assumed that they are no longer working in the nursing facility. However, this is misleading as there are many valid reasons that an employee may be on an extended leave of absence. For instance, data demonstrates that a large majority of workers in long term care are women and of child bearing age. The Family and Medical Leave Act (FMLA) allows eligible employees to be entitled to 12 workweeks of leave. There are state by state variations, that in some states result in a longer period of time (for instance in Washington D.C. 16 weeks is provided). If a nursing facility provides this leave to their employees, these employees would be counted as turned over. However, being on leave is different than leaving employment. Being on maternity leave is something that is planned and prepared for with the intention that the individual is going to return on a known date. CMS should not disincentivize policies that impact employee engagement and satisfaction. Additionally, FMLA may be triggered for individuals who are taking care of a family member with serious health concerns or if they themselves are facing a health issue. In these cases, again, the employee is not leaving employment and is planning on returning to work. It is unfair for the facility to be penalized for providing employees with the leave they deserve and is misleading to the public to report these numbers as turnover.

IV.D. Proposed Policy for Incorporating Technical Measure Updates (89 FR 23473)

CMS proposes using sub regulatory processes to incorporate technical measure updates to previously finalized SNF VBP measures. Such updates could include updating performance standards and thresholds if the measure's technical specifications for case-mix or risk-adjustment have changed.

AHCA Comments:

- **AHCA does not support using sub regulatory processes to make changes to performance standards already established. Changing the achievement or benchmark rate without proper notice defeats the purpose of setting goals to foster quality improvement. Further, the SNF VBP program is intended to reward improvement and comparing staffing hours per resident day (HPRD) that are case-mix adjusted using RUV-IV in the baseline period and then PDPM-adjusted in the performance period does not fairly measure improvement between providers.**
- **When technical measure updates are needed outside of regulatory rule making, the affected measure should be excluded and suppressed for all providers. The SNF VBP incentive payment multiplier can be based on the other measures, as there is an established policy for calculating scores when providers do not have data for all measures.**

IV.E. Proposed Updates to the SNF VBP Review and Correction Process (89 FR 23475)

CMS proposes applying the existing Phase One of the review and correction process to all measures, including PBJ-based and MDS-based measures.

AHCA Comments:

- **For long-stay hospitalization, AHCA supports defining the 'snapshot date' to include up to the 3 months following the final quarter of the applicable baseline period or performance period. Allowing changes to the underlying claims is consistent with existing practices and snapshot window definitions for short-stay claims measures, like SNF RM.**
- **Instead of the proposed 45 days after each quarter, allow PBJ corrections for up to 3 months after the end of the applicable baseline period or performance period. Allowing 3 months provides consistency with the claims-based measure. If we consider claims-based measures as the 'gold-standard' of measurement and want other data sources to be as close to this standard as possible, then we need to treat them similarly where possible.**
- **For the MDS-based measures discharge function and falls with major injury, AHCA supports defining the 'snapshot date' as 4.5 months after the last day of the applicable baseline or performance period. This more closely aligns with the claims-based window than the proposed PBJ snapshot date of 45 days each quarter.**

CMS should provide facilities a preview report (like the 1705D PBJ Staffing Data Report) after the final submission is complete for the quarter. After this point, facilities should be provided at least 15 days to review and correct the PBJ data submitted so that information available to residents and families is accurate. Currently, if a facility utilizes a vendor to submit data on their behalf, they are held responsible for errors in the data even if the vendor has made an error, outside of the facility's control. For instance, a facility can accurately report their data to a vendor and a vendor could have an error in their reports which excludes reporting RN hours. In addition to vendor issues, there may be unexpected circumstances where despite a facility's good-faith efforts to accurately submit the PBJ data timely, there is an error or missed information that is later identified by the facility. Per CMS current policy, there are no options for the facility to correct that data and the result is consumers do not have all the information available to them.

Correcting historic data is more important today because the recently developed PBJ nurse turnover measure used in SNF VBP requires six consecutive quarters of PBJ data. If any quarter of data is missing or unusable, staff turnover rates cannot be calculated or may be flawed. Thus, leaving consumers and families in the dark on a facility's true performance and not being able to use the measure in SNF VBP. Ultimately, allowing for corrected PBJ data will help ensure more facilities have their Medicare reimbursement tied to accurate staffing levels and turnover.

IV.F. Proposal To Expand the Reasons SNF May Submit an Extraordinary Circumstance Exception (ECE) Request (89 FR 23477)

CMS proposes to expand this policy to also allow a SNF to request an ECE if the SNF can demonstrate that, as a result of the extraordinary circumstance, it cannot report SNF VBP data on one or more measures by the specified deadline.

AHCA Comments:

- **We support expanding the ECE policy to include when providers cannot report data on the measures.**
- **The process for submitting and receiving an exemption should be aligned and streamlined across programs, such as SNF QRP and SNF VBP. The current proposal requires a provider to submit the same information separately to the SNF QRP and SNF VBP email inboxes when the underlying rationale and measure impacted are the same. If an exemption is granted elsewhere by CMS for PBJ, MDS, or claims data submissions, that exemption should automatically transfer to the SNF VBP program for the affected provider.**

V. Nursing Home Enforcement-Comments on Provisions of the Proposed Regulations (89 FR 23477)

AHCA/NCAL believes that the proposed revisions to the civil money penalty ("CMP") enforcement mechanism set forth in CMS's proposed revisions to the nursing home enforcement provisions (89 Fed. Reg. 23424, 23477-23481, 23489-23490 (Apr. 3, 2024) ("Proposed Rule")), which would allow the imposition of both per instance" ("PI") and "per day" ("PD") CMPs and a three-standard survey lookback period are inconsistent with the federal statute, congressional intent, and agency authority, and should be withdrawn. In addition, the proposed revisions to allow imposition of multiple PI CMPs for more than one area of noncompliance is duplicative enforcement and should be withdrawn. AHCA/NCAL submits the following comments to address these concerns in greater detail.

V.A. The Proposed Imposition of Concurrent "Per Instance" and "Per Day" CMPs is Inconsistent with Congressional Intent and Agency Authority

AHCA/NCAL is deeply concerned about proposed revisions to 42 C.F.R. §§ 488.408(e)(2)(ii) and 488.430(a) to "expand [CMS] authority to impose both a PI CMP and a PD CMP . . . when surveyors identify noncompliance." 89 Fed. Reg. at 2348. AHCA/NCAL believes that this expansion of authority exceeds CMS's delegated authority and conflicts with congressional intent.

Where Congress has "directly spoken to the precise question at issue"—here the purpose and mechanisms of nursing home enforcement—the agency must thereby act in accordance with its intent. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 942 (1984). Here, Congress intended that nursing home enforcement actions be remedial in nature, rather than punitive. Accordingly, CMS must limit its enforcement mechanisms (including CMPs) to the level necessary to promote compliance with the participation requirements and effect remediation; CMPs exceeding this threshold would be punitive and contrary to agency authority as delegated by Congress.

The plain language of the applicable Medicare and Medicaid Acts' enforcement provisions, as amended by the Omnibus Budget Reconciliation Act of 1987("OBRA '87"), refers to "remedies," not "sanctions," in relation to enforcement authority. Pub. L. No. 100-203, Title IV, §§ 4201-18, 101 Stat. 1330, 1330-160-1330-221 (codified at 42 U.S.C. §§ 1395, *et seq.*, 1396, *et seq.*). This reading of the unambiguous language of the statute finds support in legislative history and the

agency's own statements acknowledging the remedial nature of the enforcement regime. Prior to OBRA '87, there were only two enforcement mechanisms available: imposition of an admissions ban or termination from the Medicare and/or Medicaid program. *See* 42 U.S.C. § 1395cc (1994); 42 C.F.R. §§ 489.52-.66; 54 Fed. Reg. 5373 (Feb. 2, 1989). By enacting OBRA '87, Congress authorized the use of alternative remedies, including CMPs, as additional enforcement mechanisms. *See* 101 Stat. 1330, 1330-179-1330-182. Nevertheless, Congress cast its intent as remedial, rather than punitive, by emphasizing that ***remedies*** may be used to ensure ***compliance***. *See* H.R. Rep. No. 100-391, pt. 1 at 472-76 (instructing the Secretary and states to utilize particular remedies "whenever necessary to promote compliance with the requirements of participation and assure high quality care for nursing facility requirements" and noting that, with regard to CMPs, "[it] is essential to creat[e] a financial incentive for facilities to maintain compliance with the requirement of participation."). CMS has itself recognized Congress's remedial—not punitive—intent in prior rulemaking. *See* 59 Fed. Reg. 56,116, 56,199 (Nov. 10, 1994) (noting the purpose of all remedies is to protect residents from inadequate care and to motivate providers to promptly comply with the participation requirements so they may continue to provide quality services).

Moreover, the statutory framework provides for various options of authorized remedies (not just CMPs) to be considered in the interest of assuring compliance and promoting quality of care. *See* 42 U.S.C. § 1395i-3(h)(2)(A) ("Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary ***to remedy a skilled nursing facility's deficiencies***.") (emphasis added); 42 U.S.C. § 1396r (h)(1) (same, as applied to state regulatory authorities). Perhaps most notably, Congress delegated the Secretary authority to enumerate specific criteria for imposing remedies, subject to the requirement that "[s]uch criteria shall be ***designed so as to minimize the time between the identification of violations and final imposition of the remedies*** and shall ***provide for the imposition of incrementally more severe fines*** for repeated or uncorrected deficiencies." 42 U.S.C. § 1395i-3(h)(2)(B) (emphasis added); *see also* 42 U.S.C. § 1396r (h)(2) (same, as applied to state regulatory authorities).

In addition, there are substantial differences in CMS's application of CMPs across healthcare settings further driving inconsistent remedial practices. For example, CMS only allows PD CMPs to be used for hospital settings and not PI CMPs. A PD and a PI CMP may not be imposed simultaneously for the same deficiency in home health (*See* § 488.845(a)(3)) and hospice (*See* § 488.1245(a)(3). This proposal would deviate CMP imposition significantly for nursing homes as compared to other providers. In hospice settings, a CMP may only be imposed for the number of days of noncompliance since the last standard survey, including the number of days of immediate jeopardy. Home health (*See* § 488.845(d)(1)(i)) and hospice (*See* § 488.1245(d)(1)(i)) PD CMPs start at the beginning of the last day of the survey, versus assessing back as early as the noncompliance was identified by CMS or the state. Overall, the nursing home enforcement proposal in this rule would cause further inconsistencies across settings and exacerbate the punitive nature of CMPs in nursing homes in a much more extreme manner than CMS's use of CMPs in many other settings including hospitals, home health, and hospice.

If finalized, the Proposed Rule would not only expand the scope of the agency's ability to impose CMPs beyond that which Congress authorized by statute but would result in the use of CMPs that would have a more attenuated influence over quality of care than other available remedies, such as directed plans of correction or directed in-service training. CMS also has resources within its

purview to assist nursing homes with viable and sustainable improvements to quality of care. CMS can use the Quality Improvement Organizations ("QIOs") for the purpose for which they were designed ("to improve quality of care to people with Medicare") as another mechanism to improve quality, as opposed to punishment for noncompliance, which only deters quality improvement. The concurrent imposition of both PI and PD CMPs raises the potential for higher fines for the same conduct, without specifically providing for the incremental increases for uncorrected deficiencies that are contemplated in the statute. Concurrent PI and PD CMPs would effectively transform the remedial intent of CMPs—aimed at securing regulatory compliance—into something punitive. The Proposed Rule makes CMPs the focus of enforcement, with little recognition of other remedies, such as directed plans of action, which are more directly aligned with correcting noncompliance. Considering Congress's clear intent that enforcement mechanisms be remedial (not punitive) and the absence of guardrails to prevent overzealous imposition of CMPs, the Proposed Rule exceeds CMS's administrative authority.

Congress spoke clearly that enforcement mechanisms in this area were to be remedial. CMS therefore lacks authority to impose CMPs that serve a primarily punitive purpose. For this reason, CMS should withdraw these provisions of the Proposed Rule.

V.B. The Proposed Rule is Inconsistent with CMS's Prior Interpretations and Stated Intent

When CMS (then the Health Care Financing Administration ("HCFA")) issued its proposed PI CMP rule in 1999, AHCA had serious concerns about whether the agency had the statutory authority to do so, given the express statutory language for "per day" CMPs. Without conceding whether the agency has that authority, we nonetheless observe that the agency stated that PI CMPs were needed to address violations without the need to schedule revisits by the survey team in order to determine the amount of the CMP. 64 Fed. Reg. 13,354, 13357 (March 18, 1999). But the agency expressly declined to permit both PI and PD CMPs:

> When considering whether a money penalty will be used as a remedy, the survey agency must also decide whether to establish the penalty on the basis of per day or per instance. **This regulation does not authorize the use of both.** When compliance with Federal requirements is evaluated by the survey agency and a decision is reached to impose a civil money penalty, a concomitant decision must be made whether the civil money penalty will be based on a determination of per instance or per day.

Id. at 13356 (emphasis added). Accordingly, the regulation (42 C.F.R. § 488.430) states that "CMS or the State may impose a civil money penalty for either the number of days a facility is not in substantial compliance with one or more participation requirements **or** for each instance that a facility is not in substantial compliance, regardless of whether or not the deficiencies constitute immediate jeopardy."

For over 20 years, the agency has operated under this enforcement regime, using the scope and severity "grid" as a basis for progressively more severe remedies based on the scope and severity of deficiencies. In this rulemaking, CMS has not articulated a reasoned basis for deviating from this longstanding policy interpretation. *See Am. Wild Horse Pres. Campaign v. Perdue*, 873 F.3d 914, 923 (D.C. Cir. 2017) ("A central principle of administrative law is that, when an agency

decides to depart from decades-long past practices and official policies, the agency must at a minimum acknowledge the change and offer a reasoned explanation for it."); *see also Ry. Labor Executives' Ass'n v. Nat'l Mediation Bd.*, 29 F.3d 655, 669-70 (D.C. Cir. 1994) ("it is surely noteworthy that [the Board's historical] constructions do not in any way endorse the current position of the Board").

CMS positions the Proposed Rule as an effort to ensure CMPs are imposed more consistently across the country. *See* 89 Fed. Reg. at 23479. However, the inconsistent results seen at present result, at least in part, from inconsistent application and enforcement of existing rules by regulatory authorities. Providing greater flexibility and discretion in imposing CMPs is inherently incompatible with consistency. Where regulators fail to consistently apply the existing rules, there is little reason to believe that greater discretion would result in anything other than greater inconsistency. AHCA/NCAL believes that existing inconsistencies can be better resolved through other means (such as training and improved guidance to regulators) rather than adding punitive remedies to the enforcement arsenal.

V.C. If Finalized, the Proposed Rule Should Clarify That the Cumulative Total of CMPs (both "Per Day" and "Per Instance") Must Not Exceed the Statutory Daily Maximum

As set forth above, AHCA/NCAL believes that the provisions of the Proposed Rule proposing to revise 42 C.F.R. §§ 488.408(e)(2)(ii) and 488.430(a) to "expand [CMS] authority to impose both a PI CMP and a PD CMP" should be withdrawn. 89 Fed. Reg. at 23480; *see supra* Sec. II. But at a bare minimum, any change to the enforcement regulations must include language clearly limiting the aggregate total of PI and PD CMPs to no more than the daily statutory maximum. Under the Medicare Act, the Secretary may impose a CMP in an amount not to exceed $10,000 for each day of noncompliance." 42 U.S.C. § 1395i-3(h)(2)(B)(ii). Similarly, the Medicaid Act states that each state shall establish a remedy for "a civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d)." *Id.* § 1396r(h)(2)(A)(ii).[1] The plain reading of the Medicare and Medicaid Acts clearly mandates daily CMPs and limits the assessment and imposition of CMPs to a per day basis, referencing "each day" of noncompliance. CMS acknowledges in the preamble to the Proposed Rule that its authority to impose CMPs is "not to exceed the statutory and regulatory maximum amount on any given day even when combined, when surveyors identify noncompliance." 89 Fed. Reg. at 23480. However, the proposed regulatory language itself does not expressly include the limit.

To avoid any risk of confusion or misapplication—and prevent this rulemaking from creating a loophole to exceed daily statutory and regulatory CMP limits— AHCA/NCAL recommends that the proposed revisions to 42 C.F.R. § 488.408(e)(2)(ii) explicitly state that the statutory and regulatory maximum applies to the aggregate of PI and PD CMPs. AHCA/NCAL recommends that the last sentence be revised to state, "The aggregate per instance civil money penalty and per day civil money penalty may not exceed $10,000 (as adjusted annually under 45 CFR part 102) for each day of noncompliance."

V.D. Imposing Multiple "Per Instance" CMPs for More Than One Area of Noncompliance Constitutes Duplicative Enforcement

Imposing multiple PI CMPs for more than one area of noncompliance within a citation is a duplication of enforcement, as facilities are also cited based on the level of scope and severity. The scope component takes into account whether the incident was isolated, patterned, or widespread. If patterned or widespread, it is counting more than one instance of noncompliance. Facilities' CMPs are currently calculated based on the scope and severity of a citation, and adding additional PI penalties is essentially adding double penalties.

V.E. The Proposed Three-Standard-Survey Lookback Period is Inconsistent with the Statute and Congressional Intent and Introduces the Potential for Arbitrary and Inconsistent Enforcement, Contrary to Agency Intent

AHCA/NCAL also expresses significant concern regarding the proposed revision to 42 C.F.R. § 488.430 to allow a three-standard-survey lookback period for purposes of imposing retroactive CMPs. *See* 89 Fed. Reg. at 23480-23481. This proposed provision conflicts with the federal statute and Congress's intent that substantial compliance is the appropriate measure in determining imposition of remedies. Moreover, the proposal is not rationally related to CMS's stated goal of ensuring consistency across CMS regions. *See id.* at 23480. In fact, this proposal could increase, rather than decrease, the inconsistency in imposition of remedies across the country. For these reasons, and those set forth below, AHCA/NCAL believes this proposed provision should be withdrawn.

The statutory framework for imposing remedies is based on a standard of "substantial compliance" with program requirements. *See* 42 U.S.C. §§ 1395i-3(h)(3)(E),1396r (h)(4) ("a finding to deny payment under this subsection shall terminate when the State or the Secretary . . . find that the facility is in ***substantial compliance*** with the [participation] requirements of subsections (b), (c) and (d)") (emphasis added). Likewise, the statutory provisions governing SNF provider agreements are based on a determination of whether the provider has failed to ***comply substantially*** with participation requirements. *See id.* § 1395cc(b)(2)(A) & (B). These provisions existed before OBRA '87, which did not change the standard of substantial compliance. Rather, the provisions of OBRA '87 and the resulting revised enforcement system for nursing facilities focus on the correction of deficiencies and remedies in lieu of termination for noncompliance. *See* H.R. Rep. No. 100-391, pt. 1 at 472-76. Given that SNFs are evaluated against a substantial compliance standard, the look-back period should be no longer than the time since the last standard survey when the SNF was found in substantial compliance as documented on the CMS 2567B form. CMPs should not be allowed to reach back beyond the last survey's 2567B. Permitting regulatory authorities to impose CMPs for surveys that, at the time, deemed a facility in "substantial compliance" conflicts with the statutory standard and Congress's intent.

Moreover, CMS has not effectively addressed the state survey agency backlogs and delays related to initiating complaint surveys. States such as Arizona and certain States in the Southeast have complaint surveys currently taking place that include complaints made 2-3 years prior, many as far back as 2021, with the number of complaints during any one visit ranging from 75-90. These delays could have a significant CMP impact. CMS and the state survey agencies ("SSAs") should focus on improving their compliance with the current statute and regulatory timelines and not pursue additional enforcement for providers that would cause exacerbated unintended consequences due to CMS's and SSAs' own failure to meet statutory and regulatory timelines.

Moreover, CMS's proposal is inconsistent with the current regulatory system of imposing more severe remedies based upon the scope and severity of deficiencies and introduces the risk of increased arbitrary retroactive enforcement, contrary to CMS's stated intent in proposing the rule.

Additionally, the Proposed Rule suggests that a regulator could seek to retroactively impose CMPs for issues it could have identified at the time of the previous standard survey. This is also particularly concerning given that noncompliance across three consecutive surveys will result in denial of payment. *See* 42 U.S.C. §§ 1395i-3(h)(E),1396r (h)(D). If regulators can look back three standard surveys and retroactively determine a facility was noncompliant across that entire time period, a facility could go from being in "substantial compliance" to being denied payment with no notice or opportunity to cure deficiencies first. A scenario like this runs contrary to the remedial statutory intent by imposing severe consequences before even giving a facility a chance to comply. If finalized, this provision should also incorporate guardrails to prevent such results. One potential safeguard could be the inclusion of a provision requiring the regulatory authority to identify specific information or evidence that was not available at the time of prior survey in order to impose retroactive remedies.

Moreover, AHCA observes that CMS is continuously issuing revisions to its survey guidelines and standards, so that conduct that may constitute deficiency changes over time. At no time was this more acute than during the COVID pandemic, when standards for health and safety for long term care residents were changing on a practically weekly basis. Even as we have emerged from the pandemic, CMS periodically issues new guidance or interpretations of existing regulations. Under the Proposed Rule, it is conceivable that a regulator could, via the three-standard survey lookback provision, improperly evaluate a facility against rules, policies, and expectations that did not exist at the time a prior standard survey was conducted. Therefore, AHCA submits that CMS should not be permitted to impose aggregate PD and PI CMPs for periods when the facility was in substantial compliance with program requirements, as determined by the state survey agency.

Survey backlogs and ongoing widespread delays of SSAs not meeting statutory required timelines for standard surveys as well as significant delays by SSAs in initiating complaint surveys further emphasizes that these proposed changes should be withdrawn. For example, as of May 2024, survey backlog data showed 10 states with greater than 50% of providers with 15 or more months since last survey date and 4 states with greater than 25% of providers with more than 36 months since last survey date. (QCOR, May 2024).

V.F. The Agency's Estimated Regulatory Impact Fails to Account for Some Aspects of the Proposed Rule

According to Agency calculations, the proposed CMP rules would have caused a $25 million increase in nursing home costs for Calendar Year 2022. *See* 89 Fed. Reg. at 23489. However, this is only an estimated impact. *See id.* (noting that "[i]t is difficult to quantify the full future effect of this rule on facilities' compliance activities or costs"). CMS concedes that "[s]ince CMP amounts . . . are based on when noncompliance occurred and the level of noncompliance, we are unable to predict the number or amount of CMPs that will be imposed" but "do expect that the total amount of CMPs imposed would increase as a result of these proposals." *Id.*

AHCA/NCAL expresses concern about the unknown financial impact on nursing facilities as a result of this Proposed Rule. The Agency's estimate of financial impact on nursing facilities appears to only account for increased PI CMPs; it does not seem to account for an increase in PD CMPs. Additionally, the Agency's estimate does not seem to account for the impact of the proposed three-survey lookback period and imposition of post hoc CMPs. It is unclear whether the impact of this lookback period could even be reasonably predicted. AHCA/NCAL believes that the actual financial impact to nursing facilities would be much greater than predicted, when accounting for all aspects of the proposed CMP provisions. AHCA/NCAL recommends that the Agency further study the potential financial impact, and consider the resultant impacts on patient accessibility, quality of care, staffing, and other factors before finalizing this part of the Proposed Rule.

V.G. Policy Considerations

In addition to general regulatory concerns, AHCA/NCAL is concerned that finalizing this rule would lead to an array of negative policy consequences.

V.G.1. Greater CMPs Would Divert Funds from Nurse Staffing at a Time When Staffing is Critical

CMS has repeatedly raised concerns about nurse staffing levels at a time when facilities are struggling to hire and retain nursing personnel. AHCA's comments on the proposed minimum staffing rule extensively addressed the workforce crisis. This nursing home enforcement proposal could further harm nurse staffing by drawing on funds to pay CMPs that could otherwise be applied toward hiring, compensating, and retaining qualified nursing staff.

In addition to diverting funds away from staffing efforts, greater CMPs could jeopardize eligibility for programs that would help hire nursing staff. Specifically, the Social Security Act prohibits facilities from conducting their own Nurse Aide Training and Competency Evaluation Programs ("NATCEP") for two years if they receive a CMP of more than $12,924 (as adjusted by 45 C.F.R. § 102.3 (Table 1) for 2023). Providers have difficulty recruiting Certified Nursing Assistants ("CNAs") in general, and the imposition of this penalty (on top of other penalties) is unusually harsh. The proposed duplicative PI and PD CMPs would result in more facilities losing the opportunity to conduct NATCEP programs, thereby depriving them of a meaningful way to hire qualified CNAs.

V.G.2. Greater CMPs Would Divert Funds from Direct Patient Care

While CMPs are intended to solicit compliance, they do not have a direct impact on patient care in the same way that other available remedies—such as directed plans of correction—do. In addition to incurring higher costs, nursing facilities would need to divert money from patient care to the payment of CMPs, effectively exacerbating the issues the Proposed Rule seeks to address.

Additionally, some states require that a certain portion of revenue be allocated to patient care. The imposition of additional CMPs could make it more difficult to meet these requirements. This, in

turn, could put a facility at further risk of regulatory noncompliance or even make continued operation financially inviable.

V.G.3. Current CMP Funds are Intended to Support Quality Improvements but are Ineffective

Under existing regulations, CMPs are supposed to be used to support quality improvement initiatives. *See* 42 U.S.C. § 1395i-3(h)(B)(ii)(IV). However, the program execution has been relatively ineffective. As a result, adding more CMPs to an already ineffective CMS CMP Reinvestment Program ("CMPRP") is unlikely to effectuate real quality improvements. The CMS CMPRP has many flaws that deter having the CMP funds used or accessed as intended by statute. The program does not require transparency in how much CMP money is available because states are not currently required to post their CMPRP balance or make it publicly available. The allocation of funds varies by state, meaning there is no equitable distribution of funds. Despite high balances of CMP money in state accounts, CMS has significantly restricted the funds by implementing a stringent cap per facility to use for meaningful resident projects. This cap does not consider the number of residents in the facility or unique needs or characteristics of each facility. In addition, providers are experiencing one of the worst workforce crises on record, yet since September 2023, CMPRP funds have been restricted from access for workforce initiatives.

V.G.4. Other Remedies are Better Suited to Improving Quality of Care

As discussed throughout this comment, CMPs do not directly address patient quality of care in the way that other remedies do. For example, directed plans of action and appointments of temporary management directly impact facility administration and address identified deficiencies. CMPs, on the other hand, do not directly cure deficiencies. While they may incentivize compliance (or deter noncompliance), they do not directly change the quality of care provided. AHCA/NCAL believes that a focus on remedies with direct impacts on care quality are better suited to ensuring the provision of high-quality care than the imposition of CMPs.

V.G.5. The Increase in Complaint Surveys is an Indicator of Progress, Not Deficiency

In the Proposed Rule, CMS notes an increase in complaint surveys. *See* 89 Fed. Reg. at 23489. Contrary to Agency implications, we believe this increase is largely due to facility-reported matters, for which reporting is required and facilities should be positively recognized for self-reporting. AHCA/NCAL cautions CMS against rulemaking that would reduce facility reporting or attribute facility reporting as facility fault as this deters quality improvement and undermines the overall intent to support the provision of quality care.

V.H. Questions Regarding Survey Backlogs and Delayed Timelines

AHCA/NCAL expresses significant concerns relating to the Proposed Rule, survey backlogs, and delayed timelines. Some examples of these delays are evidenced in the data below; there are many more examples of unacceptable delays (notices past the point of a facility achieving substantial compliance) that are too numerous to list here. None of these CMPs were remedial as the facilities

had corrected the deficiencies months before the CMP was issued, thus the CMP solely served as punishment.

Facility	State	Region	CMP Type	Days between Survey and CMP Notice
Facility 1	NY	2	PD	1596
Facility 2	WA	10	PI	1440
Facility 3	WA	10	PI	1366
Facility 4	WA	10	PI	1354
Facility 5	WA	10	PI	1347
Facility 6	WA	10	PI	1337
Facility 7	ID	10	PI	1308
Facility 8	CA	9	PI	1266
Facility 9	MI	5	PI	1218
Facility 10	NY	2	PD	1203
Facility 11	MI	05	PD	522
Facility 12	MI	05	PD	522
Facility 13	CA	09	PD	496
Facility 14	CA	09	PD	496
Facility 15	NJ	02	PD	490
Facility 16	NJ	02	PD	490
Facility 17	CA	09	PI	476
Facility 18	CA	09	PI	445
Facility 19	WI	05	PD	444
Facility 20	TN	04	PI	437
Facility 21	VA	03	PD	425
Facility 22	CA	09	PD	421
Facility 23	AZ	09	PI	410
Facility 24	CA	09	PD	408
Facility 25	WI	05	PD	401
Facility 26	CA	09	PD	400
Facility 27	IN	05	PI	397
Facility 28	CA	09	PI	396
Facility 29	KY	04	PI	393
Facility 30	IN	05	PD	390
Facility 31	IL	05	PD	387
Facility 32	IL	05	PD	387
Facility 33	GA	04	PD	379
Facility 34	CA	09	PI	378
Facility 35	KY	04	PI	376
Facility 36	MI	05	PI	371
Facility 37	CA	09	PI	370
Facility 38	CA	09	PI	370

Facility 39	MI	05	PD	369
Facility 40	MI	05	PD	367

(CASPER, April 2024)

Because PD CMPs are calculated beginning the day of entry of survey until substantial compliance is achieved, AHCA/NCAL believes there should be guardrails in place to prevent increased CMPs caused by regulatory delays beyond a facility's control. AHCA/NCAL recommends safeguards to address circumstances including, but not limited to, the following:

1. A regulator initiates a survey but takes weeks to close the survey or submits a Form CMS-2567 (Statement of Deficiencies) late.
2. A regulatory backlog of Facility Reported Incidents and/or other complaints, given that PD CMPs would be imposed on the "earliest date the facility engaged in the deficient practices." [QCOR Analytic Tool User Guide, n.d.].

We also believe there are practical problems with CMS's proposal to authorize the imposition of multiple CMPs for each instance of noncompliance within the same survey. A PD CMP is calculated based on the first day of the survey in which the deficiency is identified until substantial compliance is achieved. In CMS's proposal, there could be a scenario with a facility cited for one F-Tag at an IJ level that results in a PD CMP, and two-level D F-Tags for which no CMP would be imposed. If the facility corrects the IJ deficiency immediately, within, for example, two days of notice, but the level D F-Tags are not determined to be corrected until re-visit, would the PD CMP still run from the date of the survey since the facility has not technically been determined to be in substantial compliance? In other words, there could be situations with one F-Tag as the basis for the CMP being found corrected before others, leading to multiple days of CMPs simply because the surveyors have not had time to revisit the facility. This circumstance would be compounded in the case of overlapping surveys (e.g., self-reported complaint survey and an annual survey), where there could be weeks if not months before the state agency declares the facility in substantial compliance. This proposal would continue to perpetuate the "gotcha" survey approach without a meaningful opportunity for the facility to demonstrate compliance.

Failure to Provide Notice of Intent to Include Enforcement in Proposed Rule

We also note that CMS did not provide notice of its intent to include enforcement as part of this proposed rule. Accordingly, we and other stakeholders were surprised to see such a proposal in this rule. If CMS had provided notice that an enforcement proposal would be part of this rule, AHCA/NCAL and other stakeholders would have requested the opportunity to meet with OMB. CMS should not finalize the enforcement proposals in this rule and if any enforcement proposals are to be pursued, CMS should issue a proposed rule with adequate notice to the public.

Conclusion

For all these reasons and the evidence outlined in the above comments, AHCA/NCAL believes that all these proposed revisions to nursing home enforcement are inconsistent with the federal statute, congressional intent, and agency authority, and should be withdrawn.

[1] Under 45 C.F.R. § 102.3 (Table 1), the statutory limit has been adjusted for inflation such that the maximum amount in 2023 is $25,847.

Appendix

Avalere Analysis of SNF Beneficiary Characteristics

AHCA Summary of Key Observations of Avalere Analysis of SNF Beneficiary Characteristics and Potential Impacts on Policy Decisions

Like we have done so in recent years, we have commissioned Avalere Health to provide analytic support in identifying key SNF trends. Specifically, we have analyzed key trends since the SNF PPS payment model transitioned from RUGs to PDPM as the resident classification model that are associated with beneficiary characteristics and social determinants of health factors that may impact potential policy options. The prior analyses focused on the initial implementation of PDPM, and the impacts of the COVID-19 pandemic helped inform our comments to CMS as the Agency worked to implement the recently fully implemented negative 4.6 percent parity adjustment to the SNF PPS payment model.

Now, as the COVID-19 pandemic has transitioned to an endemic status, many of the trends we have analyzed have either returned to pre-pandemic levels or have stabilized at a pattern either higher or lower than pre-pandemic levels. Additionally, some SNF Part A resident characteristics patterns have neither stabilized and, in some cases, continue to trend away from pre-pandemic levels. The attached Avalere Analysis of SNF Beneficiary Characteristics report includes thirty-six trend chart figures and one chronological table of factors that did not appear to have stabilized when we submitted our FY 2024 SNF PPS proposed rule comments. We are using this more current data to inform our recommendations in this comment letter and to suggest areas we wish to discuss further with CMS. For example, in our response to the PDPM NTA component RFI in this FY 2025 SNF PPS proposed rule, we refer to some of the data trends discussed in the following Avalere analysis.

We request that CMS engage with stakeholders regarding the potential reasons for the following trends observed in the Avalere analysis as they have not appeared to stabilize and continue to trend away from pre-pandemic levels. Such trends could be due to a variety of factors including justifiable changes in resident characteristics, structural changes in the item definition, lack of clear MDS manual or other documentation guidance, inadequate provider documentation education, or program integrity issues. Such engagement with stakeholders will help ensure that future proposed policy changes are appropriate.

1. **Avalere report trends that have not appeared to stabilize and continue to trend away from pre-pandemic levels.**

1.a. Figure 7: Percentage of SNF MDS 5-Day Assessments with Stroke and Other Neurological Conditions as Primary Medical Condition Category, Oct 2019 – Jun 2023

The percentage of SNF admissions with a Clinical Category of Other Neurological Conditions has doubled since October 2019 and continues to trend upwards through June 2023

1.b. Figure 11: Percentage of SNF MDS 5-Day Assessments with Hip and Knee Replacements, Other Orthopedic Conditions, and Amputations as Primary Medical Condition Category, Oct 2019 – Jun 2023

The percentage of SNF admissions with a Clinical Category of Other Orthopedic Conditions has increased 50 percent since October 2019 and continues to trend upwards through June 2023.

1.c. Figure 13: Percentage of SNF MDS 5-Day Assessments with a Pulmonary Diagnosis, Oct 2019 – Jun 2023

With the onset of the COVID-19 PHE the percentage of SNF admissions with a primary condition of respiratory failure nearly tripled to 15 percent and gradually increased to a level approaching 18 percent by July 2023.

1.d. Figure 16: Percentage of SNF MDS 5-Day Assessments with Malnutrition or Parenteral Feeding, Oct 2019 – Jun 2023

As discussed in the PDPM NTA component RFI discussion earlier in this comment letter, the percentage of SNF MDS 5-day assessments with malnutrition or with the patient at risk of malnutrition increased steadily from October 2019 (16%) through June 2023 (42%).

1.e. Figure 18: Percentage of SNF MDS 5-Day Assessments with Depression, Oct 2019 – Jun 2023

As discussed in the PDPM NTA component RFI discussion earlier in this comment letter, the percentage of MDS 5-day assessments with a PHQ-9 mood interview score indicating depression increased by eight percentage points from October 2019 (10% of stays) to June 2023 (18% of stays). This trend is expected to drop starting October 2023 when the MDS item changed from PHQ-9 to PHQ-2 to 9.

1.f. Figure 33: Percentage of Days with a CMG Assigned Based on Depression, 2019 – June 2023

This trend is primarily driven by the Figure 18 SNF MDS 5-day assessments with PHQ-9 mood interview scores indicating depression, however, while the Figure 18 trend chart highlight stays with a Nursing component case-mix group contains the depression adjustor, this trend chart incorporates length of stay factors to indicate the percentage of resident days with a depression indicator. It also reveals differences in reported depression prevalence in Medicare assessments between Medicaid case-mix states that use the PHQ-9 score as a payment adjustor versus non-case mix states that do not. Like Figure 18's depression stays trendline, the Figure 33 depression days trendlines have increased steadily and have nearly doubled between October 2019 and June 2023.

2. Avalere report trends that changed during the COVID-19 pandemic but do not appear to have stabilized.

2.a. Figure 3: Length of Stay for Hospitalization Prior to SNF Stay, Oct 2019 – Sep 2023

After spiking with the onset of the COVID-19 pandemic, the length of the hospital stays preceding a SNF admission increased and fluctuated throughout the PHE. While trending towards the pre-pandemic baseline by August 2023, this trend has not yet stabilized.

2.b. Figure 4: MS-DRG Weight for Hospitalization Prior to SNF Stay, Oct 2019 – Sep 2023

MS-DRG average weights of the hospital stay immediately preceding a SNF admission are a good indicator of clinical complexity and acuity. The MS-DRG average weight increased dramatically with the onset of the COVUD-99 pandemic and fluctuated throughout during the PHE, with spikes slightly lagging from COVID-19 surges, which occurs if the beneficiary first went to the hospital before the SNF stay. While overall the trendline is migrating towards the baseline MS-DRG average weight, the trendline has not stabilized.

2.c. Figure 5: Percentage of SNF Stays with Complications and Comorbidities (CC or MCC) in Acute Hospitalization Prior to SNF Stay, Oct 2019 – Sep 2023

The percentage of SNF stays where beneficiary complications and comorbidities (CC or MCC) reported in the hospital stay immediately preceding the SNF admission is another good indicator of clinical complexity and acuity. The trend pattern was like the preceding MS-DRG weight trends discussed above in that they increased upon the onset of the COVID-19 pandemic, have fluctuated with COVID-19 surges, and remains unstable at a level slightly above pre-pandemic levels.

2.d. Figure 15: Percentage of SNF MDS 5-Day Assessments with Pressure Ulcers, Oct 2019 – Jun 2023

The percentage of SNF stays where the resident had a pressure ulcer upon admission upon admission increased with the onset of the COVID-19 pandemic, with spikes slightly lagging from COVID-19 surges, which would be expected if the beneficiary first went to the hospital before the SNF stay, and the trendline is still unstable and does not appear to be returning to baseline, suggesting an ongoing more complex SNF population.

2.e. Figure 20: Percentage of SNF MDS 5-Day Assessments with Anxiety or Depression, Oct 2019 – Jun 2023

The percentage of stays for MDS 5-day assessments reflecting anxiety disorders or depression spiked early during the COVID-19 pandemic and remained at higher than pre-pandemic levels, with the greater fluctuations observed with anxiety disorders.

2.f. Figure 21: Percentage of SNF MDS 5-Day Assessments with Other Psychiatric Conditions, Oct 2019 – Jun 2023

Other psychiatric conditions such as bipolar disorder, schizophrenia, and psychotic disorders represented about ten percent of the SNF Medicare admissions prior to the COVID-19 pandemic, then spiked in April 2020 and have their prevalence had fluctuated throughout the PHE at levels above pre-pandemic levels.

2.g. Table 1: Beneficiary Demographic Characteristics, SNF Stays, FY 2019 – FY 2023

Some demographic shifts occurred during the COVID-19 PHE with regards to Medicare resident gender, age, locality, and race. Increased prevalence during the early PHE months occurred for males, those under seventy-four, those residing in rural locations, and those identified as black.

However, by FY 2023, the following demographic groups represented a smaller proportion of SNF admissions than they did pre-pandemic: people under sixty-five. people in rural locations, and people identified as black. Such a shift could be an indicator of emerging SNF access disparities as the COVID-19 pandemic shifted into an endemic status.

2.h. Figures 22 and 23: Original Reason for Medicare Entitlement, ESRD or Old Age and Survivor's Insurance, SNF Stays, FY 2019 – FY 2023

The percentage of SNF stays for beneficiaries with ESRD status as the reason for Medicare entitlement increased from a 5.7 percent distribution in FY 2019 to 6.1 percent in FY 2020 after the onset of the COVID-19 PHE, then dropped consistently to 4.7 percent of SNF admissions during FY 2023 suggesting current access issues.

2.i. Figure 24: Dual Eligibility Status, SNF Stays, FY 2019 - FY 2023

Similar to the ESRD Medicare eligibility status pattern trend in Figure 22, the percentage of SNF stays for beneficiaries with Medicare/Medicaid dual eligibility status increased from a 38.2 percent percent pre-pandemic distribution in FY 2019 to 41.9 percent in FY 2021 after the onset of the COVID-19 PHE, then dropped steadily to 36.3 percent of SNF admissions during FY 2023 suggesting current access issues.

3. Avalere report trends that changed during the COVID-19 pandemic but do appear to have stabilized at a level different from pre-pandemic levels.

3.a. Figure 1: Average SLP and Nursing CMIs, SNF Stays, Oct 2019 – Sep 2023

After peaking early in the COVID-19 PHE and during subsequent COVID surges, the SLP and Nursing component average CMIs appear to have stabilized at a slightly higher level than prior to the pandemic onset.

3.b Figure 2: Acute Hospitalizations and ED Visits in 12 Months Prior to SNF Stay, Oct 2019 – Sep 2023

After initial small spikes early in the COVID-19 PHE and a subsequent slight drop as the pandemic ensued, the average number of acute hospitalizations or emergency department visits in the year prior to SNF admission appears to have stabilized near but slightly lower than pre-pandemic levels.

3.c. Figure 8: Percentage of SNF MDS 5-Day Assessments with Non-Traumatic Brain and Spine Dysfunction, and Progressive Neurological Conditions as Primary Medical Condition Category, Oct 2019 - Jun 2023

Although the overall percentage of SNF stays with non-traumatic brain dysfunction or progressive neurological conditions was small prior to the COVID-19 pandemic, their prevalence increased about 50 percent beginning in April 2020 and remained at these elevated levels, with mild fluctuations, through June 2023.

3.d. Figure 10: Percentage of SNF MDS 5-Day Assessments with Fractures and Other Multiple Trauma and Cardiorespiratory Conditions as Primary Medical Condition Category, Oct 2019 – Jun 2023

The percentage of primary condition category of debility and cardiorespiratory conditions upon SNF admission dropped from 16 percent to less than 11 percent early in the COVID-19 PHE. While fluctuating during COVID-19 surges, the overall prevalence was stabilizing at a level of about 3 percent below pre-pandemic levels by June 2023.

3.e. Figure 14: Percentage of SNF MDS 5-Day Assessments with Incontinence, Oct 2019 – Jun 2023

As an indicator of clinical complexity, the percentage of SNF Medicare admissions where the residents had urinary or bowel incontinence upon admission each spiked more than 10 percent at the onset of the COVID-19 pandemic and that trend has stabilized for an extended period at those higher levels - over 60 percent of Part A admissions for bowel incontinence and nearly 70 percent for urinary incontinence.

3.f. Figure 35: Percentage of Days Claim Diagnosis for a SLP Comorbidity, 2019 – June 2023

The percentage of SNF days attributed to claims containing ICD-10 codes that map to a SLP component comorbidity nearly tripled from about 4 percent to 12 percent on the onset of the PDPM payment model in 2019, was only nominally impacted by the onset of the COVID-19 pandemic and then declined and has stabilized at slightly more than 9 percent of SNF resident days as of June 2023.

3.g. Figure 36: Percentage of Days CMG Assigned Based on a Mechanically Altered Diet or Swallowing Disorder, 2019 – 2021

The percentage of SNF days where a resident was assigned to a SLP component CMG assigned based on the presence of a mechanically altered diet or swallowing disorder upon admission spiked from about 35 percent to about 40 percent upon the onset of the COVID-19 pandemic, fluctuated between COVID-19 surges, then starts to stabilize at a level about two percentage points above pre-pandemic levels. There were nominal differences between states that had Medicaid case-mix payment models versus those that did not.

To: American Health Care Association (AHCA)

From: Avalere Health

Date: May 17, 2024

Re: Analyses of SNF Beneficiary Characteristics

Background

In fiscal year (FY) 2020 the Centers for Medicare & Medicaid Services (CMS) implemented a new payment policy for skilled nursing facilities (SNFs), the Patient Driven Payment Model (PDPM), with a goal of making per-diem payments to SNFs based on the characteristics of patients rather than on the volume of services provided.

In March 2020, during the first year of the PDPM, the COVID-19 pandemic began. With the start of the pandemic there were significant disruptions to the entire healthcare system. The pandemic and related quarantine policies affected all aspects of SNF operations and the patient population receiving care in SNFs was also affected. For example, elective procedures were postponed in acute hospitals and efforts were in place to preserve inpatient beds in high-impact COVID-19 areas. These pandemic-related shifts in care patterns affected discharge and post-acute care utilization for all patients, not just those receiving care for COVID-19.

The purpose of the analyses presented here is to demonstrate the changes in the characteristics and case-mix of beneficiaries treated in SNFs over the period 2019 – 2023. The first set of analyses focus on characteristics of patient case-mix based on analyses of Medicare claims and Minimum Data Set (MDS) assessment data.[1] The second set of analyses focus on demographic factors and characteristics associated with social determinants of health. A third analysis examines coding pattern changes in speech-language pathology and nursing case-mix indices using claims data. Examination of changes in these factors from 2019 – 2023 provide context for changes in the characteristics of the population relative to a period prior to the implementation of the PDPM and prior to the COVID-19 pandemic and provide a sense of how changes in patient characteristics may persist as the impact of the pandemic lessens and following the end of the public health emergency (PHE).

[1] At the time of this analysis, MDS assessment data was only available through June 2023 (with partial data from June 2023) and Medicare claims were only available through September 2023.

Changes in Case-Mix Among Beneficiaries Receiving Care in SNFs

Avalere examined the case-mix of beneficiaries receiving care in SNFs to better understand changes in the patient population during the COVID-19 pandemic. Changes in case-mix were examined through analyses of case mix indices (CMIs) recorded on the claims, prior acute hospitalizations, and emergency department (ED) visits, Hierarchical Condition Categories (HCC) risk score based on claims in the 12 months prior to SNF admission, and relevant items from the Minimum Data Set (MDS).

Methods

Avalere identified SNF stays using 100% Medicare standard analytic files (SAFs) from October 1, 2019 to September 30, 2023. SNF stays with a diagnosis code (International Classification of Diseases 10th Revision; ICD-10) of U071 (COVID-19) or with a condition code signifying the stay utilized a 3-day acute stay waiver (condition code = DR) were not included in the analyses. Note that SNF stays coded as waiver with a prior inpatient stay of 3 days or more were included in the analyses as these reflect qualifying Medicare SNF stays under current law.

CMIs were obtained from Healthcare Common Procedure Coding System (HCPCS) codes on the SNF claims. CMS HCC risk scores were calculated using 12 months of claims prior to the SNF admission date. The community risk scores were used for the purposes of the analyses presented here unless the beneficiary was new to Medicare or had some months of Medicare Advantage in the 12 months prior to SNF admission, in which case they were assigned the "new enrollee" risk score, which was based entirely on demographic characteristics and no claims data.

Avalere also analyzed MDS 5-day prospective payment system (PPS) assessment data from October 2019 through June 2023 to learn more about the characteristics of beneficiaries upon admission to a SNF. Assessment data noting COVID-19 diagnoses were excluded but assessments for waiver stays were not excluded as waiver status is not identifiable on the MDS. Specific case-mix related MDS items examined included primary condition at admission (e.g., neurological, orthopedic, and cardiorespiratory conditions), and other conditions present at admission including respiratory conditions, depression, delirium, incontinence, pressure ulcers, malnutrition, behavioral symptoms, and psychiatric conditions.

Weekly COVID-19 case rates were obtained from the Centers for Disease Control and Prevention.[2]

Results

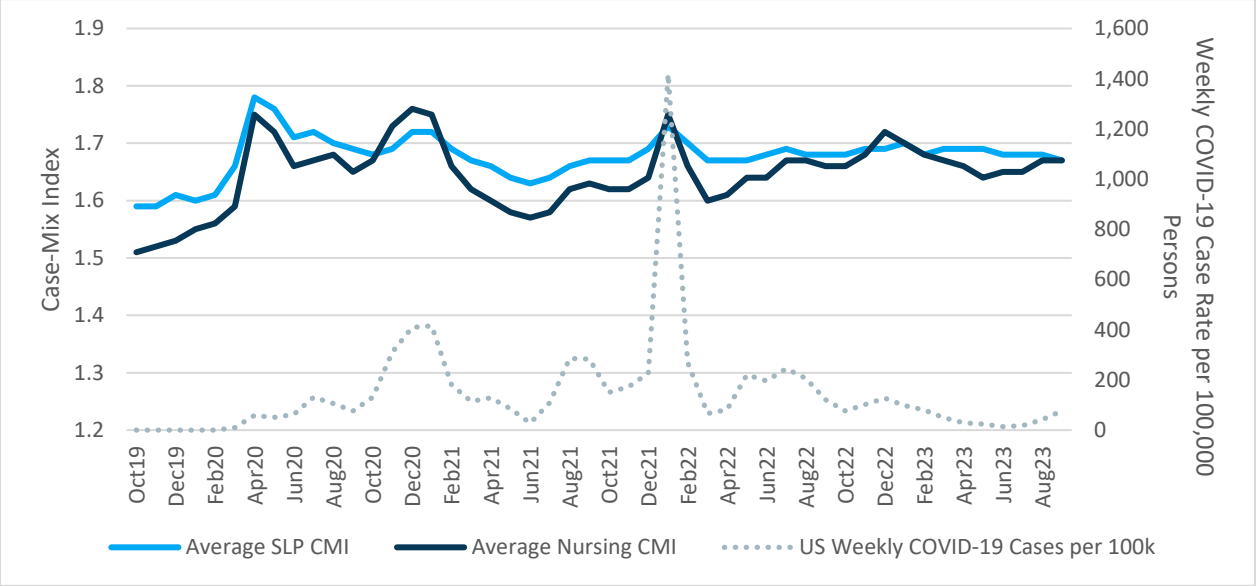
Case-Mix Indexes

Speech-language pathology (SLP) and nursing CMIs had been increasing after the PDPM transition, with a sharp peak at the start of the COVID-19 pandemic (**Figure 1)**. SLP and nursing

[2] Centers for Disease Control and Prevention. "COVID-19 Weekly Cases and Deaths by Age, Race/Ethnicity, and Sex," February 2024. Available here.

CMIs later declined but remained higher than pre-pandemic levels through 2023, with minor peaks during periods of high COVID-19 case rates.

Figure 1: Average SLP and Nursing CMIs, SNF Stays, Oct 2019 – Sep 2023

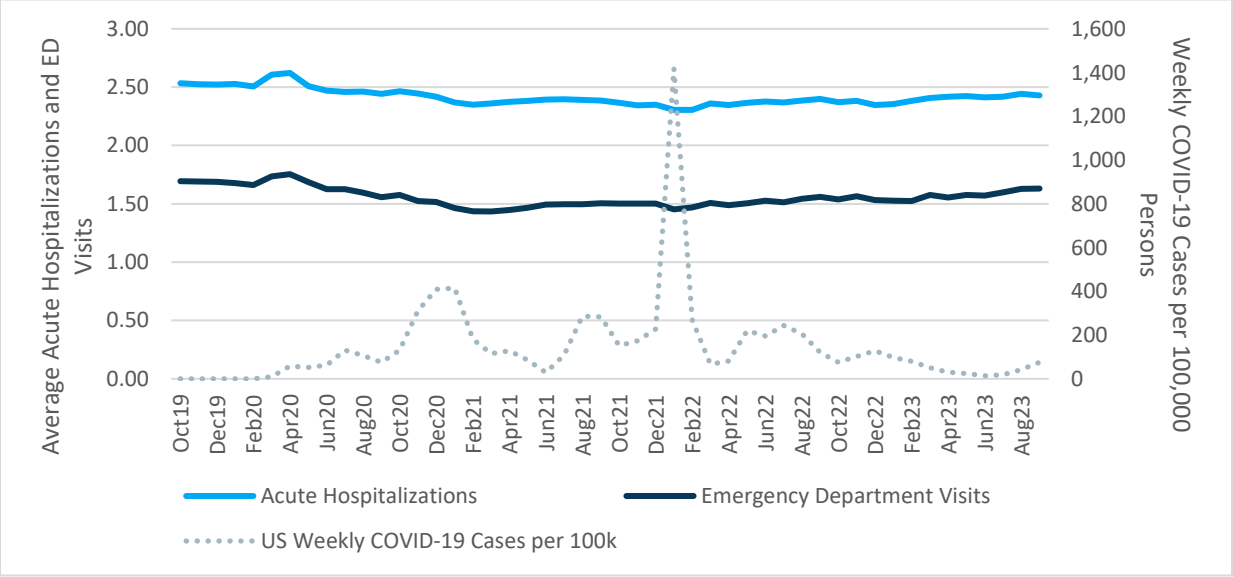


Source: Avalere analysis of 100% Medicare Claims Files Oct 2019 – Sep 2023

Claims-Based Case-Mix Analysis

The average number of acute hospitalizations and ED visits for patients in the 12 months prior to a SNF stay had been decreasing slightly before the pandemic (**Figure 2**). Patients entering SNFs at the start of the pandemic had slightly higher inpatient and ED utilization, but this generally continued to decrease throughout the pandemic and remained relatively constant.

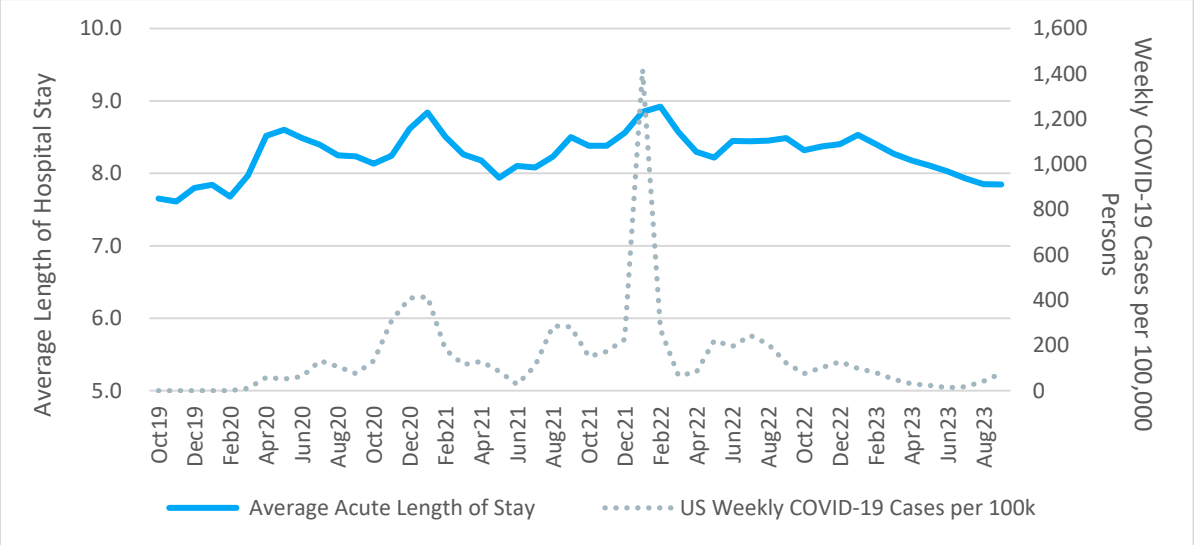
Figure 2: Acute Hospitalizations and ED Visits in 12 Months Prior to SNF Stay, Oct 2019 – Sep 2023



Source: Avalere analysis of 100% Medicare Claims Files Oct 2019 – Sep 2023

For SNF stays with a prior hospitalization, the average length of stay for the acute hospitalization prior to a SNF stay was increasing after the PDPM transition and showed additional peaks at the start of the COVID-19 pandemic and during subsequent January 2021 and 2022 spikes in COVID-19 case counts (**Figure 3**). The average prior acute hospitalization length of stay has remained higher than October 2019 levels through the beginning of 2023, after which average length of stay prior to a SNF stay has trended down toward pre-pandemic levels.

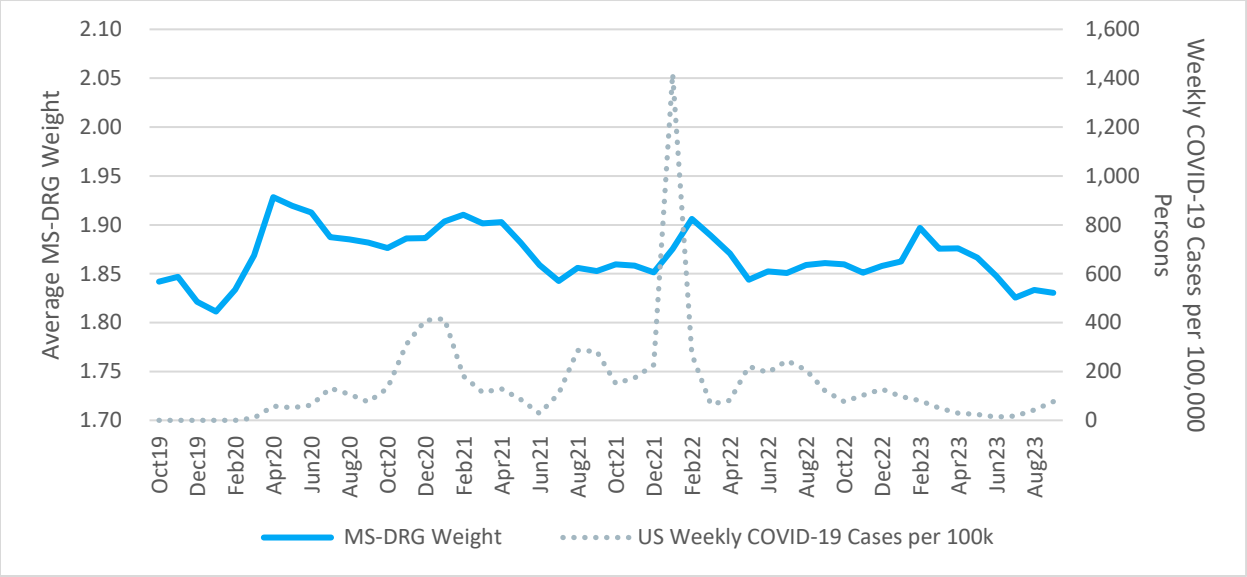
Figure 3: Length of Stay for Hospitalization Prior to SNF Stay, Oct 2019 – Sep 2023



Source: Avalere analysis of 100% Medicare Claims Files Oct 2019 – Sep 2023

The average MS-DRG weight of the hospitalization prior to a SNF stay had been decreasing after the PDPM transition (**Figure 4**). The average weight then increased sharply at the start of the pandemic and during the subsequent January 2021 and 2022 spikes in COVID-19 case counts. The average prior acute hospitalization MS-DRG weight remained higher than October 2019 levels through early 2023. Following the small spike in February 2023, the average MS-DRG weight has continued to decline in 2023 slowly returning to pre-pandemic levels.

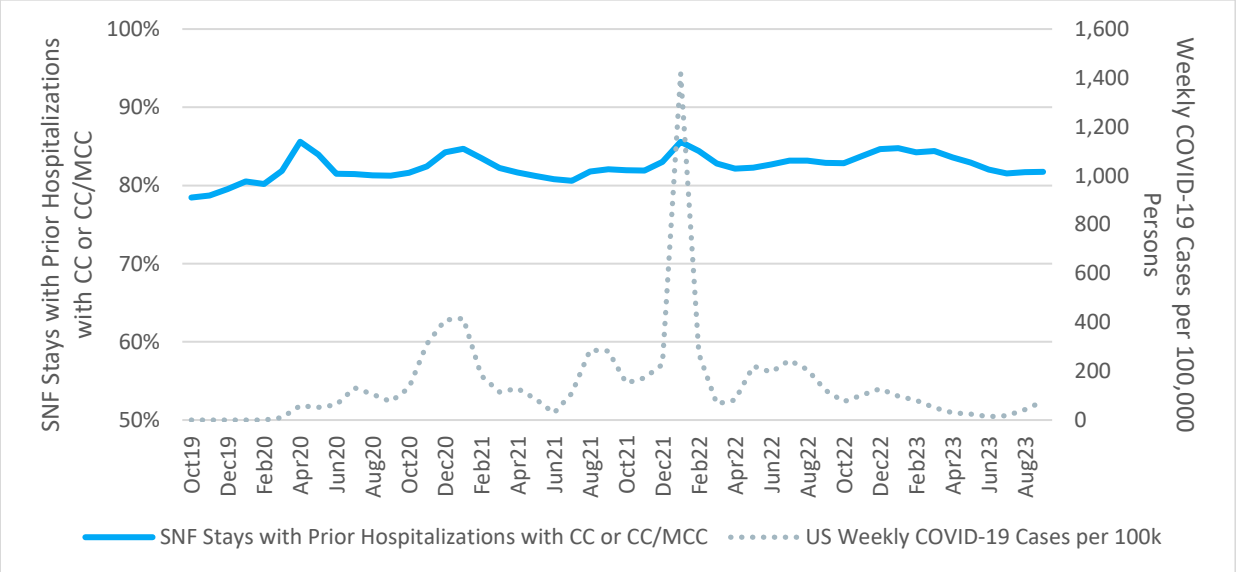
Figure 4: MS-DRG Weight for Hospitalization Prior to SNF Stay, Oct 2019 – Sep 2023



Source: Avalere analysis of 100% Medicare Claims Files Oct 2019 – Sep 2023

The percentage of SNF stays with a prior hospitalization with a complication (MS-DRG CC or MCC) increased after the PDPM transition, with additional increases at the start of the pandemic and during COVID-19 peaks of January 2021 and 2022 (**Figure 5**). The percentage of SNF stays with a prior hospitalization with a complication remained higher than October 2019 levels through 2023 but has started to return closer to pre-pandemic levels in Q3 2023.

Figure 5: Percentage of SNF Stays with Complications and Comorbidities (CC or MCC) in Acute Hospitalization Prior to SNF Stay, Oct 2019 – Sep 2023

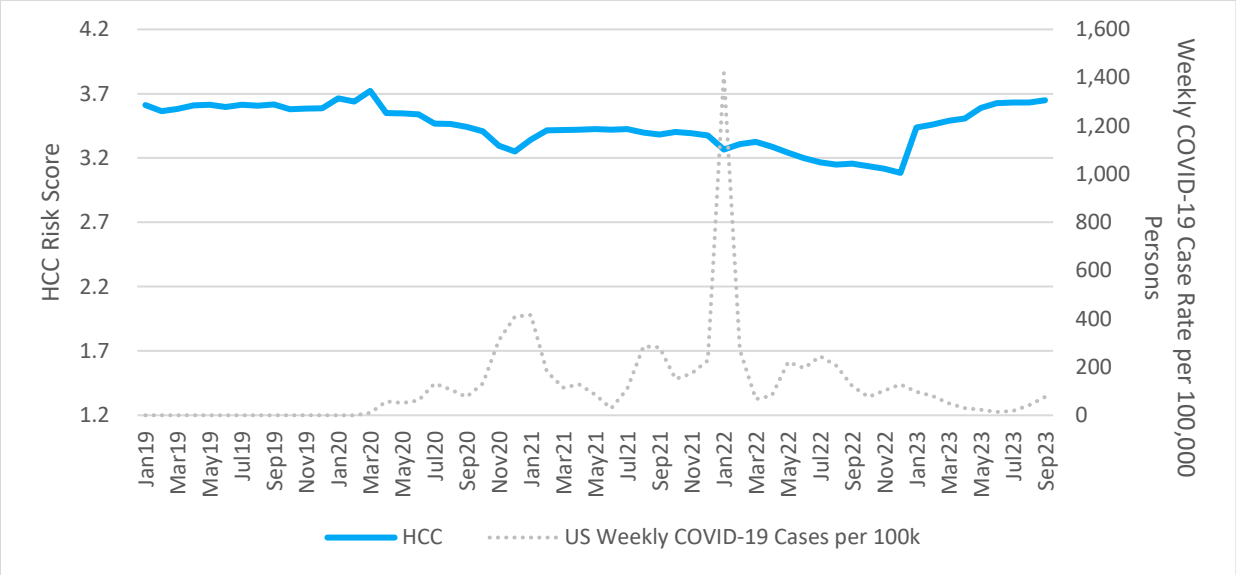


Source: Avalere analysis of 100% Medicare Claims Files Oct 2019 – Sep 2023

HCC Risk Score

HCC risk scores stayed relatively constant through early 2020 with a small increase at the start of the pandemic. Average risk scores were lower in periods where there was an increase in average weekly COVID-19 cases (for example December 2020 and January 2022). From the end of 2022 through 2023, average HCC risk scores for beneficiaries have slowly increased and returned to pre-pandemic levels.

Figure 6: Average HCC Risk Score, SNF Stays, January 2019 - September 2023



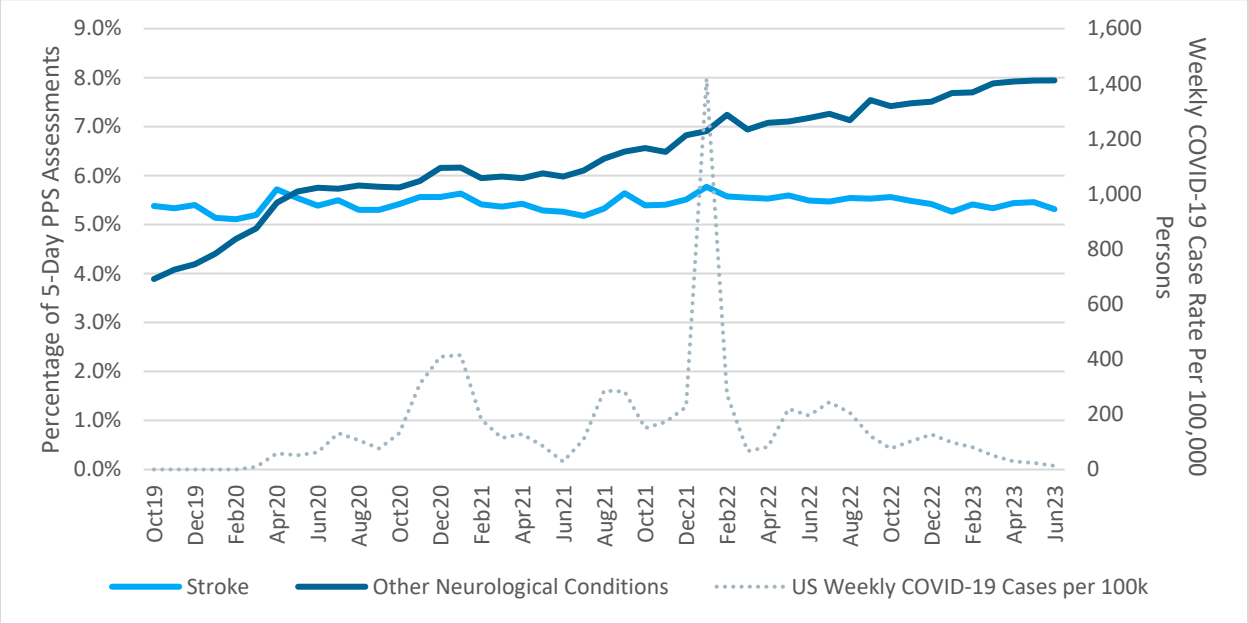
Source: Avalere analysis of 100% Medicare Claims Files Jan 2019 – Sept 2023

MDS Assessment Items: Primary Medical Condition Category

The MDS 5-day PPS assessment records the primary medical condition category and other diagnoses for non-COVID SNF patients. Many conditions showed changes prior to and during the COVID-19 pandemic.

The percentage of MDS 5-day assessments with a primary medical condition of other neurological conditions increased at the onset of the pandemic and continued to increase into June 2023 (**Figure 7**). MDS assessments with this primary diagnosis increased 4.1 percentage points from October 2019 to June 2023. Assessments with a primary medical condition of stroke increased slightly as a percentage of all 5-day assessments at the onset of the pandemic and during COVID-19 surges in 2021 but were generally stable through June 2023.

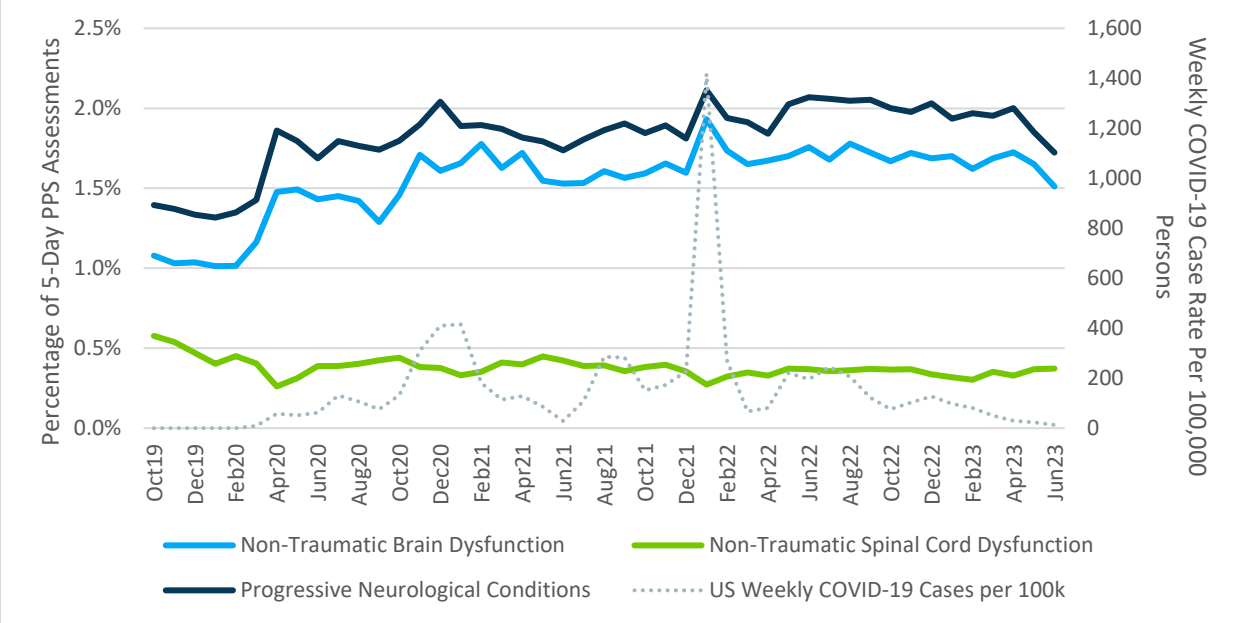
Figure 7: Percentage of SNF MDS 5-Day Assessments with Stroke and Other Neurological Conditions as Primary Medical Condition Category, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

Non-traumatic brain dysfunction and progressive neurological conditions were infrequent as primary conditions on SNF MDS 5-day assessments (<2%); however, both increased slightly as a percentage of all 5-day assessments after the pandemic started in April 2020, increased again during subsequent COVID-19 surges, and have remained above pre-pandemic levels (**Figure 8**).

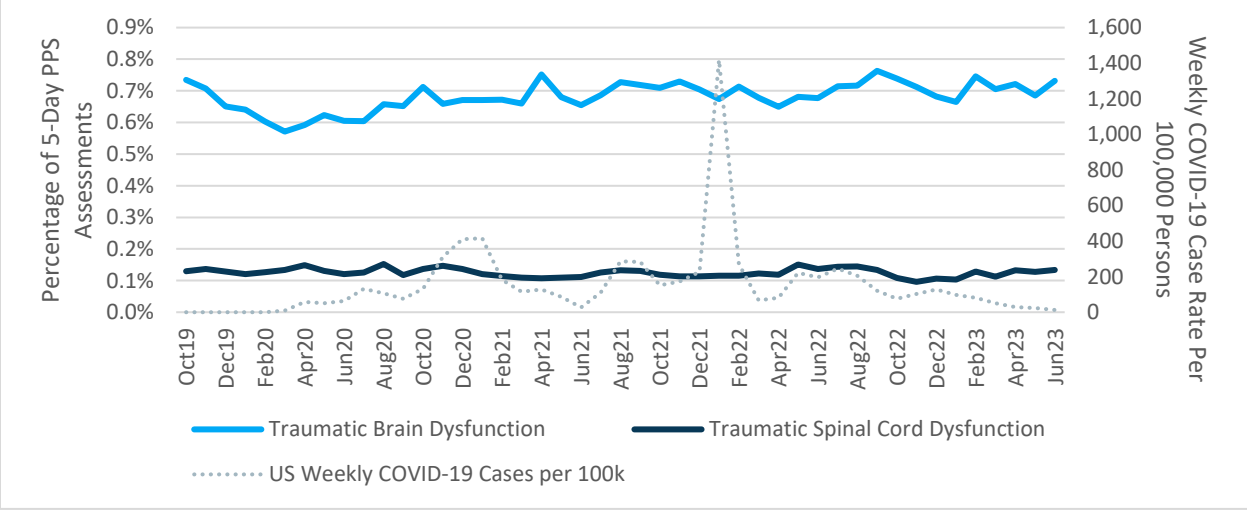
Figure 8: Percentage of SNF MDS 5-Day Assessments with Non-Traumatic Brain and Spine Dysfunction, and Progressive Neurological Conditions as Primary Medical Condition Category, Oct 2019 - Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

Traumatic brain dysfunction and spinal cord dysfunction were also infrequent as primary conditions on SNF MDS 5-day assessments (<1%). Traumatic brain dysfunction had been decreasing as a percentage of 5-day assessments leading up to the pandemic but increased slightly after April 2020 (**Figure 9**) with a few additional spikes in August 2022 and February 2023. The percentage of 5-day assessments with traumatic spinal cord dysfunction as the primary medical condition remained relatively flat throughout the pandemic.

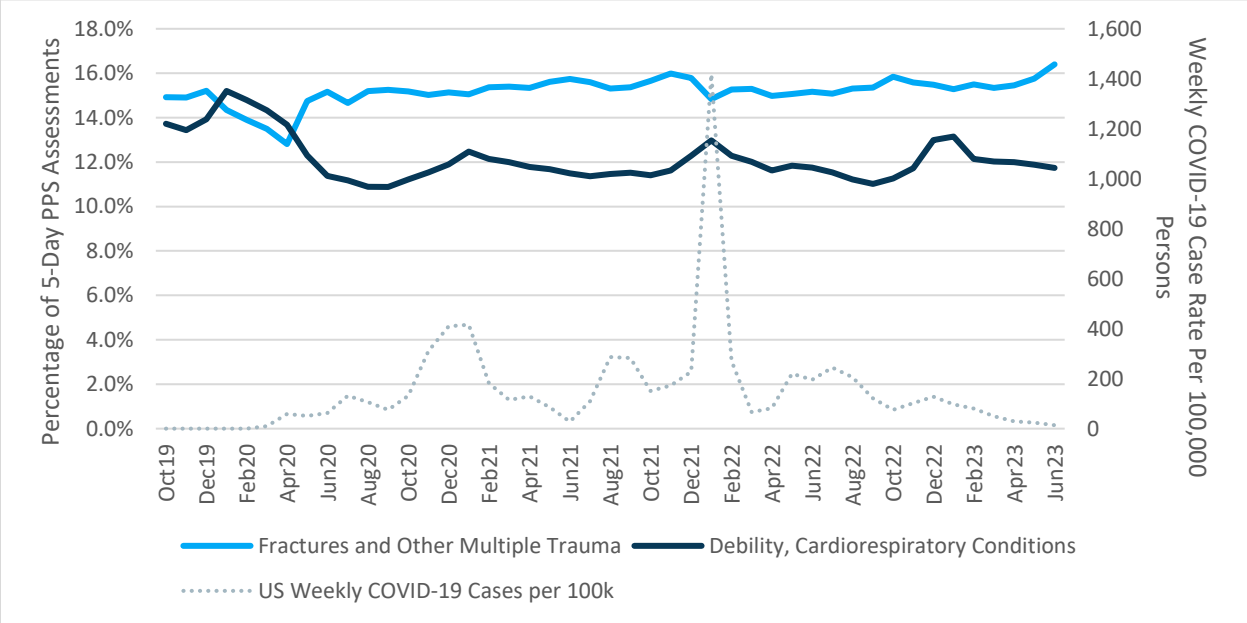
Figure 9: Percentage of SNF MDS 5-Day Assessments with Traumatic Brain and Spine Dysfunction as Primary Medical Condition Category, Oct 2019 - Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

Primary medical conditions of fractures and other multiple trauma decreased as a percentage of all SNF MDS 5-day assessments prior to the start of the pandemic and returned to 2019 levels early in the pandemic, and remained relatively flat through June 2023 (**Figure 10**). The percentage of SNF MDS 5-day assessments with debility and cardiorespiratory conditions as primary medical conditions dropped slightly with the onset of the pandemic and were a smaller percentage of SNF MDS 5-day assessments through June 2023 than they were pre-COVID-19 pandemic, with small surges corresponding to peaks in COVID-19 rates.

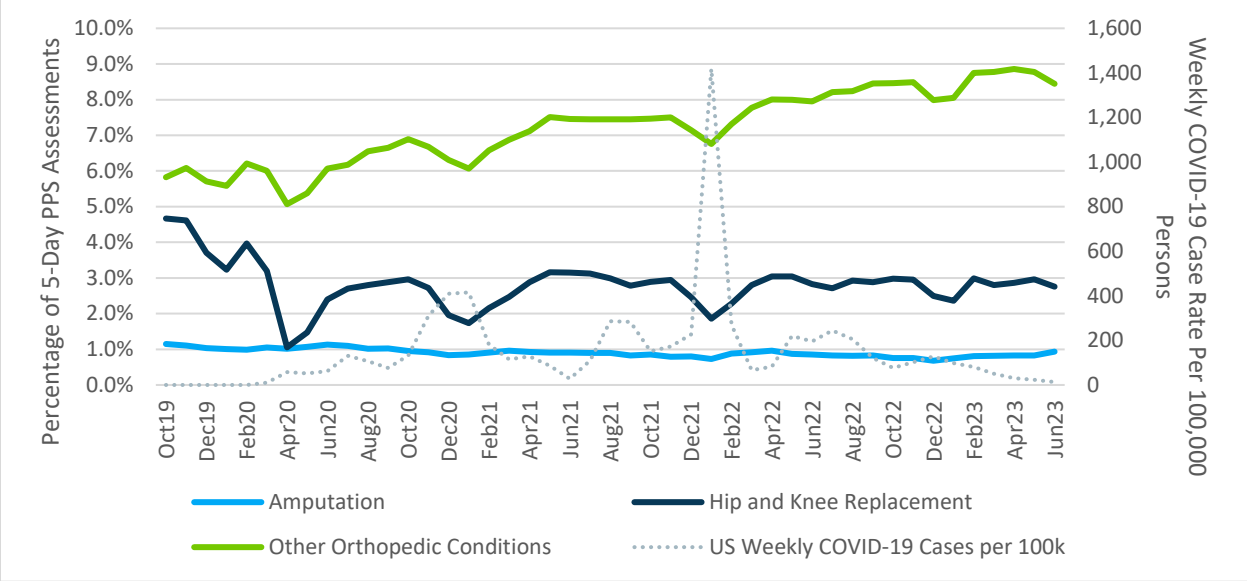
Figure 10: Percentage of SNF MDS 5-Day Assessments with Fractures and Other Multiple Trauma and Cardiorespiratory Conditions as Primary Medical Condition Category, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The percentage of 5-day assessments with hip and knee replacement as the primary medical condition dropped 2.9 percentage points between February 2020 and April 2020 and still had not returned to pre-pandemic levels by June 2023 (**Figure 11**). Other orthopedic conditions increased 2.6 percentage points as a percentage of total SNF MDS 5-day assessments between October 2019 and June 2023. Both hip and knee replacement and other orthopedic conditions dropped during the COVID-19 surges. Amputations were rarely the primary medical condition (~1%) and the percentage of 5-day assessments with amputation as the primary condition remained flat throughout the pandemic.

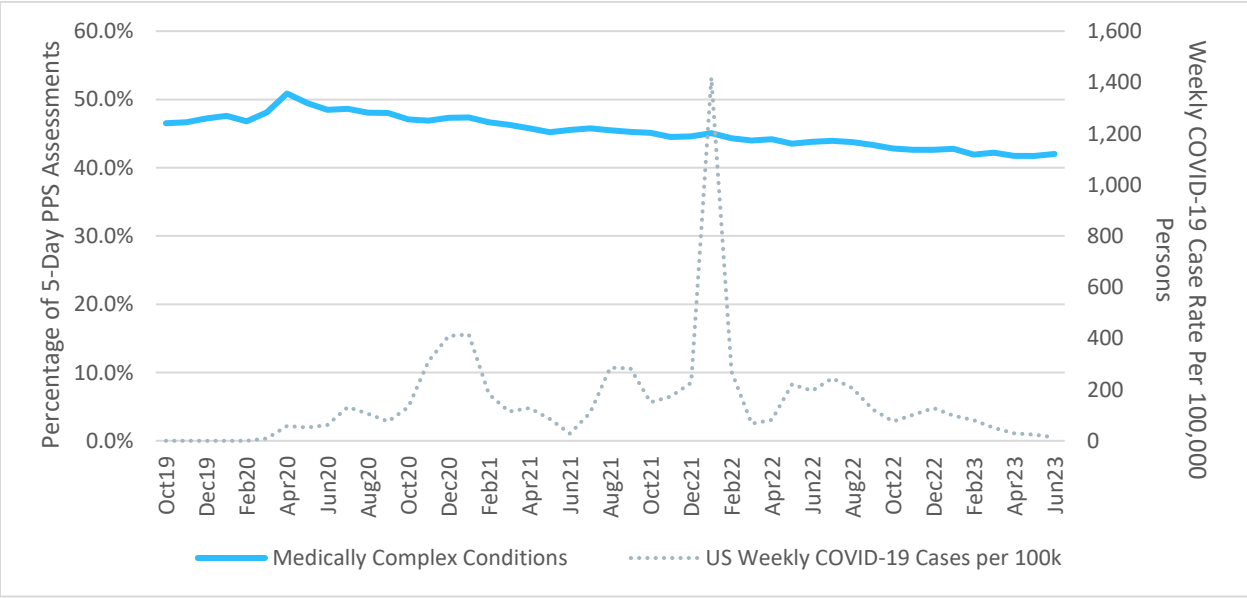
Figure 11: Percentage of SNF MDS 5-Day Assessments with Hip and Knee Replacements, Other Orthopedic Conditions, and Amputations as Primary Medical Condition Category, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The percentage of SNF MDS 5-day assessments with medically complex conditions as the primary condition category increased 4.1 percentage points between February 2020 (46.8%) and April 2020 (50.9%) (**Figure 12**). After the initial increase, 5-day assessments with medically complex conditions returned to pre-pandemic rates by October 2020 and decreased another 5.1 percentage points by June 2023 (42.0%).

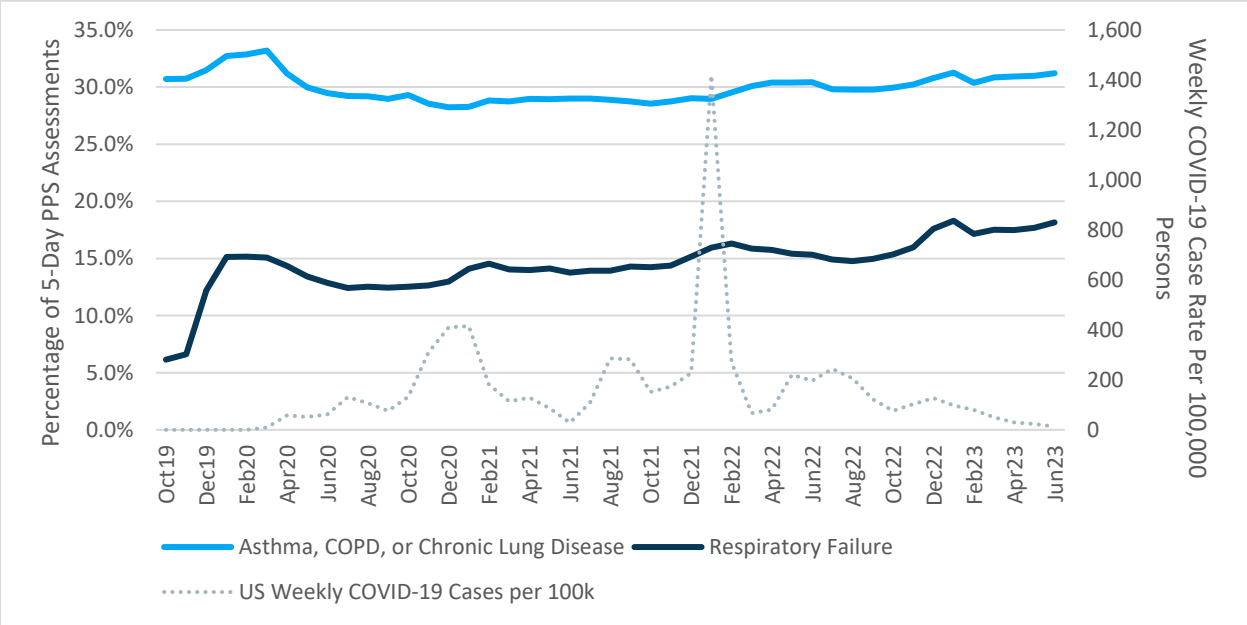
Figure 12: Percentage of SNF MDS 5-Day Assessments with Medically Complex Conditions as Primary Medical Condition Category, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The increase in the percentage of SNF MDS 5-day assessments with respiratory failure leading up to and at the start of the pandemic was notable and continued increasing through June 2023 (**Figure 13**). The percentage of MDS 5-day assessments with asthma, COPD, or chronic lung disease increased at the start of the pandemic but returned to pre-pandemic levels by summer 2020.

Figure 13: Percentage of SNF MDS 5-Day Assessments with a Pulmonary Diagnosis, Oct 2019 – Jun 2023

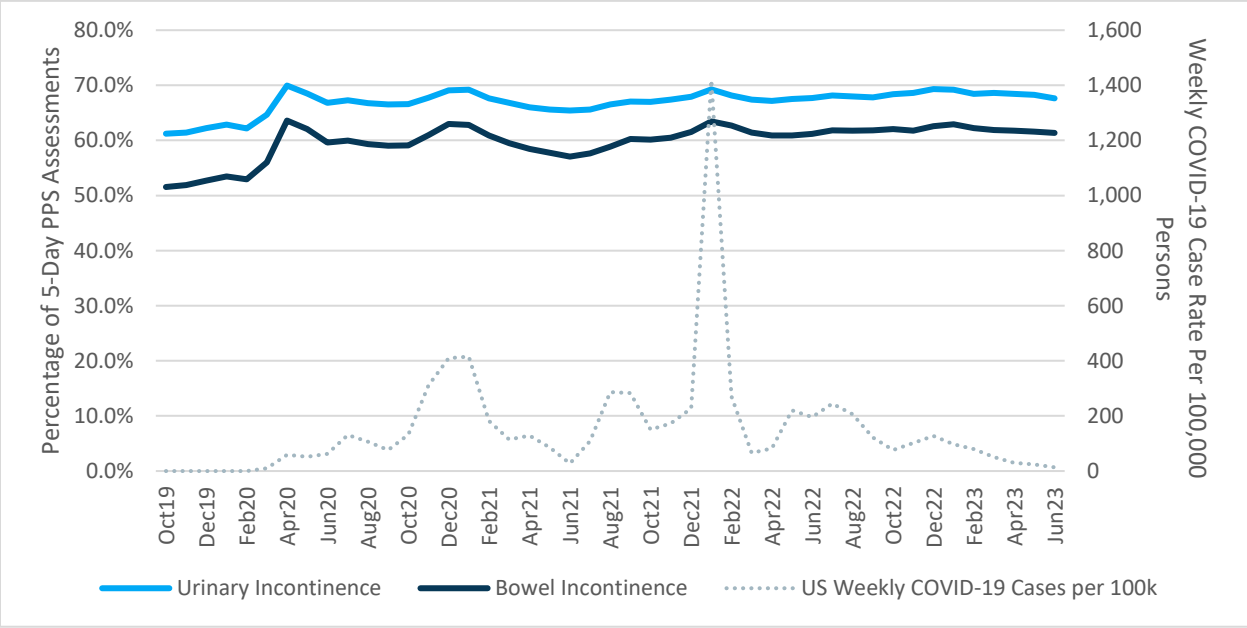


Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

MDS Assessment Items: Other Conditions

The percentage of SNF MDS 5-day assessments indicating bladder or bowel incontinence upon admission increased during the pandemic, with peaks during the initial COVID-19 onset and during the January 2021 and 2022 surges (**Figure 14**). Urinary incontinence increased 5 percentage points from 65% to 70% of 5-day assessments from March 2020 to April 2020 and bowel incontinence increased 8 percentage points from 56% to 64%. Both measures were lower by June 2023 than during the peak of April 2020, but remained 6% and 10%, respectively, above pre-pandemic levels.

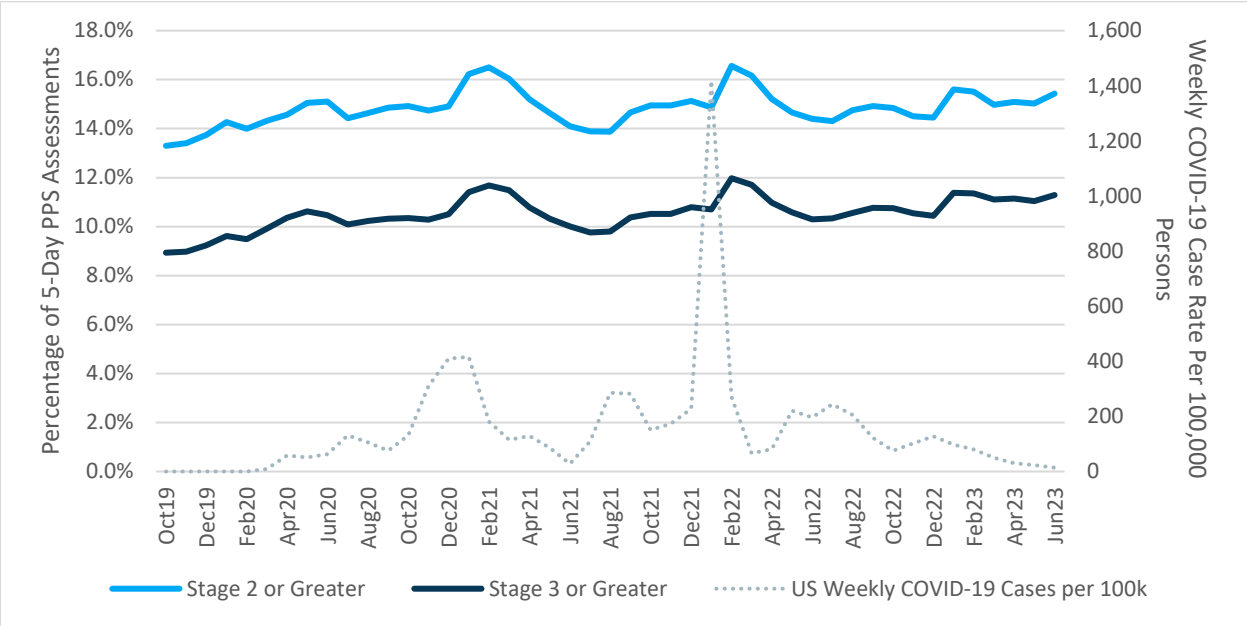
Figure 14: Percentage of SNF MDS 5-Day Assessments with Incontinence, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The percentage of SNF MDS 5-day assessments with pressure ulcers and injuries upon admission also increased during the pandemic (**Figure 15**). The percentage of 5-day assessments with a stage 3 or greater pressure ulcer increased from 9% in October 2019 to peaks of 12% in February 2021 and February 2022. The percentage of 5-day assessments with a stage 2 or greater pressure ulcer increased from 13% in October 2019 to 17% in February 2021 and February 2022. Both measures appeared to peak, with a short delay, after the onset of the COVID-19 pandemic and after the major COVID-19 surges of January 2021 and 2022, with another small peak after December 2022. The percentage of assessments with pressure ulcers remained elevated through June 2023 relative to prior to the COVID-19 pandemic.

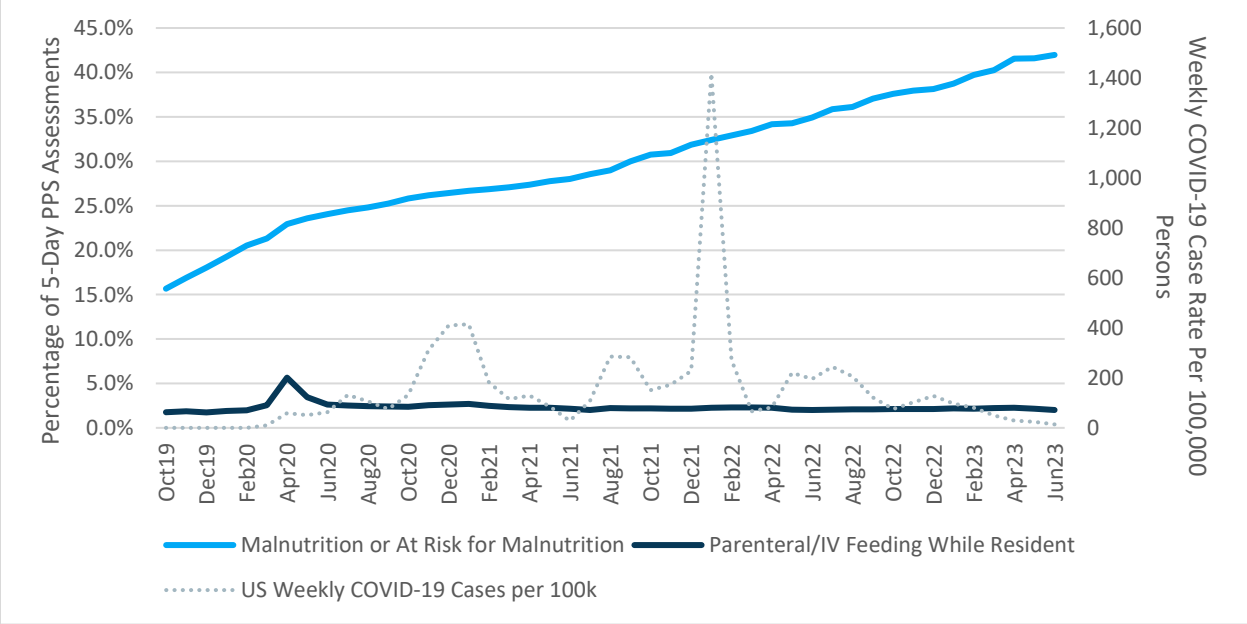
Figure 15: Percentage of SNF MDS 5-Day Assessments with Pressure Ulcers, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The percentage of SNF MDS 5-day assessments with malnutrition or with the patient at risk of malnutrition increased steadily from October 2019 (16%) through June 2023 (42%) (**Figure 16**). The percentage of 5-day assessments where the patient received parenteral or IV feeding increased at the start of the pandemic but returned to pre-pandemic levels by summer 2020.

Figure 16: Percentage of SNF MDS 5-Day Assessments with Malnutrition or Parenteral Feeding, Oct 2019 – Jun 2023

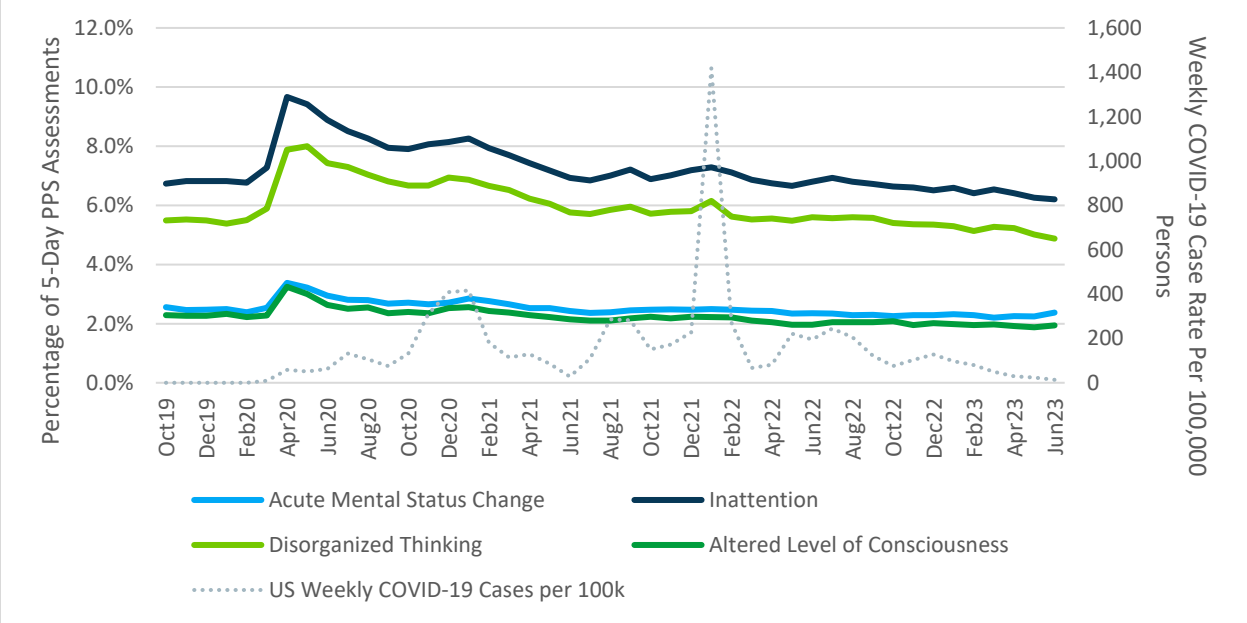


Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

MDS Assessment Items: Behavioral and Psychological Conditions

The MDS also collects data on signs and symptoms of delirium including acute mental status change, inattention, disorganized thinking, and altered level of consciousness, and all 4 indicators increased in March and April of 2020 relative to pre-pandemic levels (**Figure 17**). The observed increase in acute mental status change and altered level of consciousness in March and April of 2020 was small (1 percentage point) and dissipated by summer 2021. Inattention and disorganized thinking increased 3 and 2 percentage points, respectively, as a percentage of all MDS 5-day assessments from February 2020 to April 2020. Rates of assessments with inattention and disorganized thinking has returned to pre-pandemic levels in since 2022.

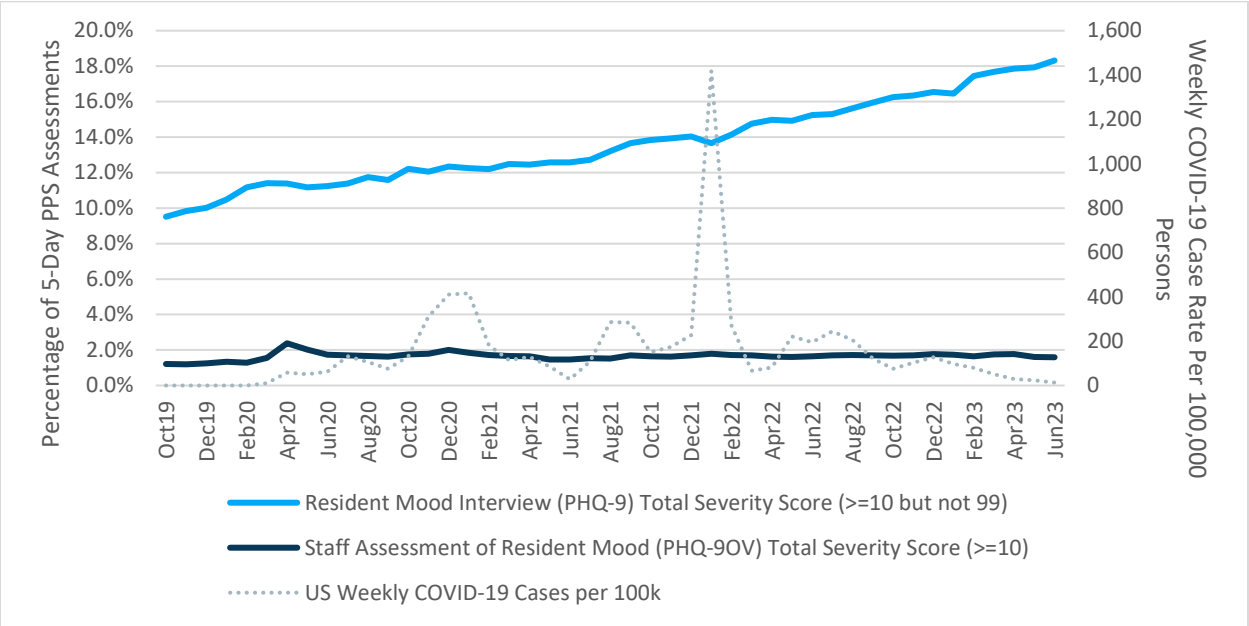
Figure 17: Percentage of SNF MDS 5-Day Assessments with Symptoms of Delirium, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

Moderate to severe depression, as measured by the Resident Mood Interview (PHQ-9) Total Severity Score (>=10), increased steadily through June 2023 (**Figure 18**). The percentage of MDS 5-day assessments with a PHQ-9 score indicating depression increased by 8 percentage points from October 2019 (10% of stays) to June 2023 (18% of stays). Depression as measured by the Staff Assessment of Resident Mood (PHQ-9OV) Total Severity Score (>=10) was less common (1-2%) and observed changes during the pandemic were small.

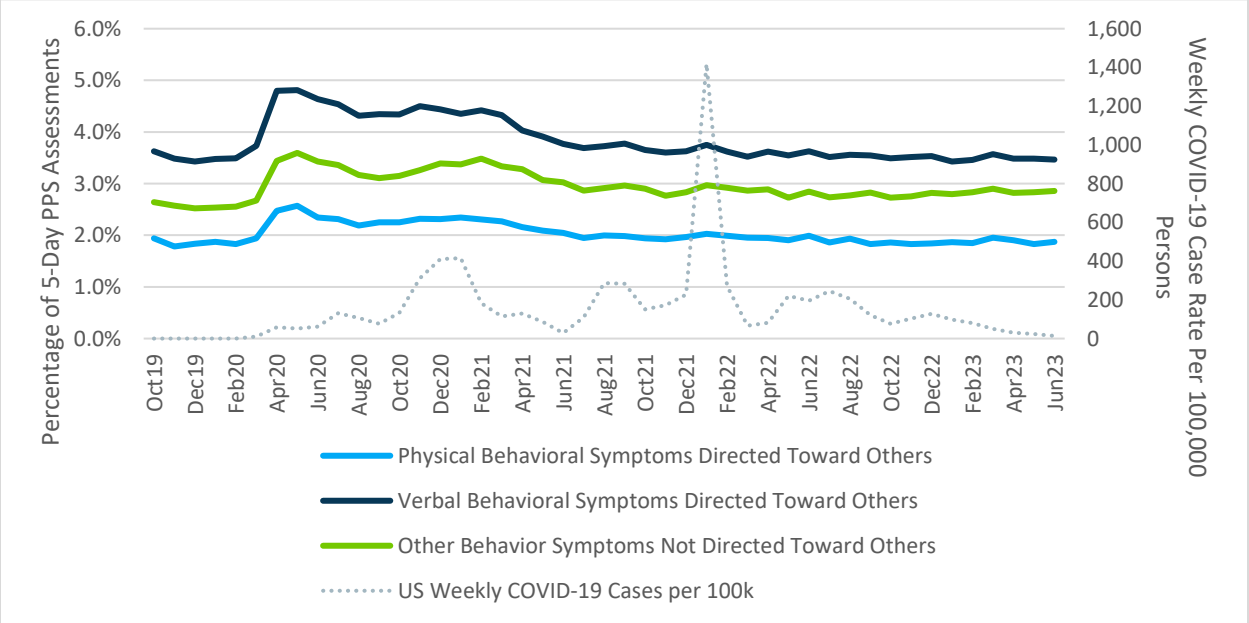
Figure 18: Percentage of SNF MDS 5-Day Assessments with Depression, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The proportion of SNF MDS 5-day assessments with behavioral symptoms also increased with the onset of the COVID-19 pandemic (**Figure 19**). Rates of behavioral symptoms returned to pre-pandemic levels by summer 2021.

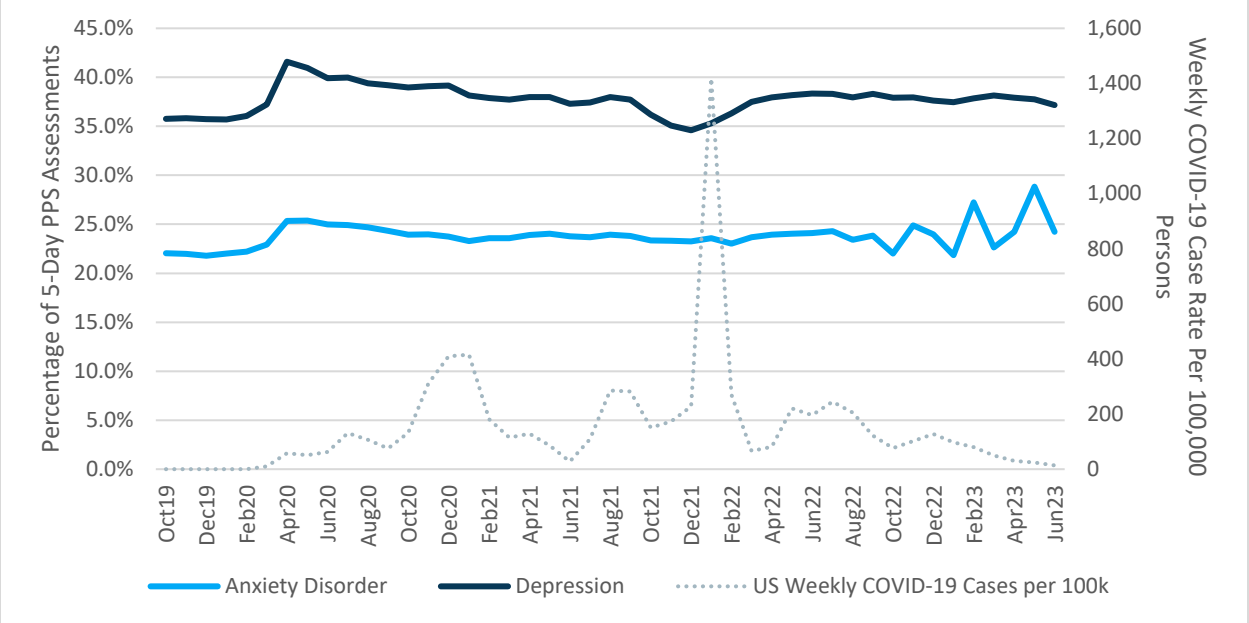
Figure 19: Percentage of SNF MDS 5-Day Assessments with Behavioral Symptoms, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The percentage of SNF MDS 5-day assessments with an anxiety disorder or depression increased 3 and 6 percentage points, respectively, at the start of the pandemic. The percentage of 5-day assessments with an anxiety disorder remained above pre-pandemic levels through September 2022, then fluctuated through June 2023. The percentage of 5-day assessments with depression returned to pre-pandemic levels in fall 2021 but increased following the January 2022 surge and remained high through June 2023.

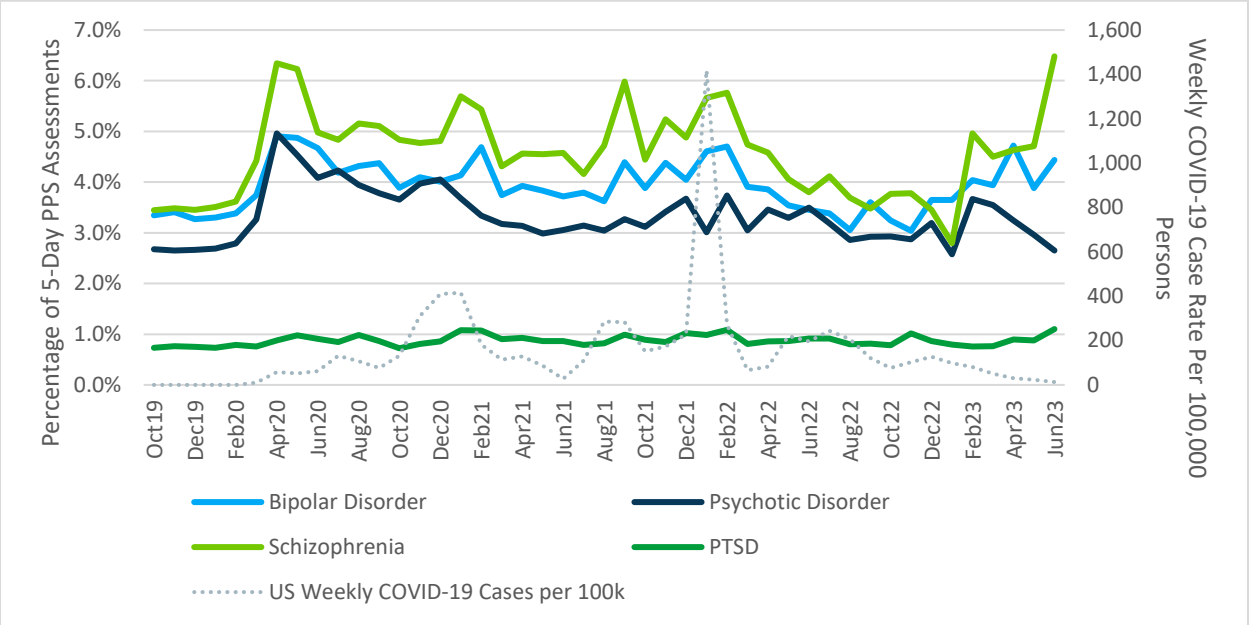
Figure 20: Percentage of SNF MDS 5-Day Assessments with Anxiety or Depression, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The percentage of SNF MDS 5-day assessments with bipolar disorder, psychotic disorder, or schizophrenia increased at the start of the pandemic and continued to fluctuate throughout 2021 and 2023.The percentage of 5-day assessments with PTSD remained relatively flat through June 2023.

Figure 21: Percentage of SNF MDS 5-Day Assessments with Other Psychiatric Conditions, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

Changes in Demographics and Social Determinants of Health Among Beneficiaries Receiving Care in SNFs

Avalere explored demographic characteristics and social determinants of health among beneficiaries receiving care in SNF across FY 2019 – Q3 FY 2023 (hereafter referred to as FY 2023) using several data sources. First, we analyzed claims-based beneficiary characteristics from Medicare claims. Second, we linked claims data to social determinants of health data elements from the American Community Survey (ACS), and third, we analyzed relevant items from the Minimum Data Set (MDS).

Methods

Avalere identified SNF stays from the 100% Medicare standard analytic files from October 1, 2019 to September 30, 2023. SNF stays with a diagnosis code (International Classification of Diseases 10th Revision; ICD-10) of U071 (COVID-19) or with a condition code signifying the stay utilized a 3-day acute stay waiver (condition code = DR) were not included in the analyses except for figures noted below to show the differences in COVID-19 versus non COVID-19 stays.

Demographics, such as age, sex, race, original reason for Medicare entitlement, and an indicator of end stage renal disease (ESRD), came directly from the Medicare claims and enrollment data. Beneficiary zip codes were obtained from the Medicare enrollment files and used to link to the ACS data to identify the characteristics of a beneficiary's area of residence. ACS variables analyzed included mean net worth, poverty status, educational attainment, and insurance coverage. Avalere also analyzed MDS 5-day prospective payment system (PPS) assessment data to learn more about the characteristics of beneficiaries upon admission to a SNF including marital status and need for interpreter services.

Results

There were small differences in the percentage of SNF beneficiaries who were male versus female and the average age of beneficiaries receiving care in SNFs over the course of the pandemic (**Table 1**). The proportion of SNF stays for male beneficiaries increased from 41.4% in FY 2019 to 43.4% in the second half of FY 2020, while the proportion of SNF stays for female beneficiaries was slightly lower in FY 2021-FY 2023 compared to FY 2019. On average, SNF stays during FY 2020 and FY 2021 were for younger beneficiaries than before the pandemic. In the first half of FY 2020, 66.8% of SNF stays were among those ages 75 and older; in the second half of FY 2020, this decreased to 64.2%. By FY 2022 and FY 2023, the percentage of SNF stays among patients ages 75 and older returned to 67.6% and 68.9% respectively.

Relatively small changes in the racial / ethnic composition of SNF stays were observed from FY 2019- FY 2023.

The percentage of SNF stays from beneficiaries in rural areas decreased since the start of the pandemic. In FY 2019, 15.5% of SNF beneficiaries resided in rural areas; by FY 2023, only 14.4% of SNF beneficiaries were from rural areas.

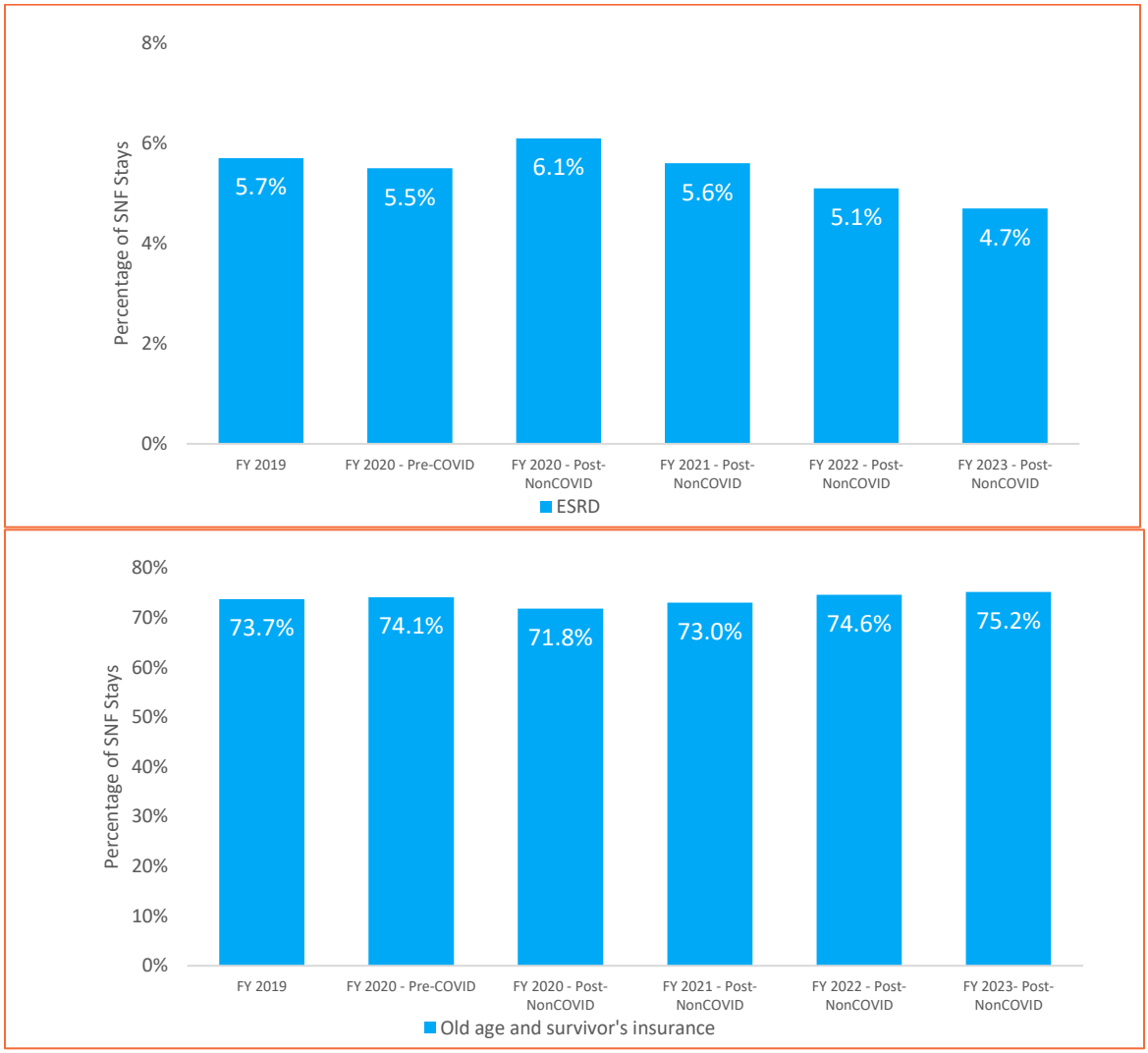
Table 1: Beneficiary Demographic Characteristics, SNF Stays, FY 2019 – FY 2023

	FY 2019	FY 2020 (Q1 & Q2)	FY 2020 (Q3 & Q4)	FY 2021	FY 2022	FY 2023 (Q1-Q3)
Sex						
Percent Male	41.4%	41.6%	43. 2%	42.9%	42. 3%	42.2%
Percent Female	58.6%	58.4%	56.8%	57.1%	57.6%	57.7%
Age						
Percent <65	9.6%	9.2%	10.1%	9.4%	8.1%	7.4%
Percent 65-74	24.0%	24.1%	25.6%	25.4%	24.2%	23.5%
Percent 75-84	32.9%	33.0%	32.3%	33.3%	34.7%	35.7%
Percent 85+	33.6%	33.8%	31.9%	31.9%	32.9%	33.2%
Locality						
Percent Rural	15.5%	15.3%	16.3%	15.0%	14.6%	14.4%
Race						
Percent White	82.9%	82.9%	82.7%	82.6%	82.8%	82.7%
Percent Black	11.6%	11.5%	11.9%	11.8%	11.2%	10.9%
Percent Asian	1.4%	1.5%	1.3%	1.3%	1.4%	1.5%
Percent Hispanic	1.7%	1.8%	1.6%	1.7%	1.7%	1.7%
Percent North American Native	0.5%	0.6%	0.6%	0.6%	0.5%	0.5%
Percent Other/Unknown	1.8%	1.9%	1.8%	2.0%	2.3%	2.6%

Source: Avalere analysis of 100% Medicare Claims Files, Acxiom, and ACS data Oct 2019 – Sept 2023

Avalere found that the percentage of SNF stays where beneficiaries were originally entitled to Medicare due to ESRD increased between the first and second half of FY 2020 (**Figure 22**). However, this percentage returned to pre-pandemic levels in FY 2021 and decreased further in FY 2022 and FY 2023. Similarly, the percentage of SNF stays where the original reason for entitlement was old age and survivor's insurance decreased 2.8 percentage points between the first and second half of FY 2020 and has continued to return to pre-pandemic levels (**Figure 23**). A smaller percentage of entitlement through old age and survivor's insurance indicates a greater percentage of patients for whom entitlement was due to disability insurance benefits or ESRD.

Figures 22 and 23: Original Reason for Medicare Entitlement, ESRD or Old Age and Survivor's Insurance, SNF Stays, FY 2019 – FY 2023

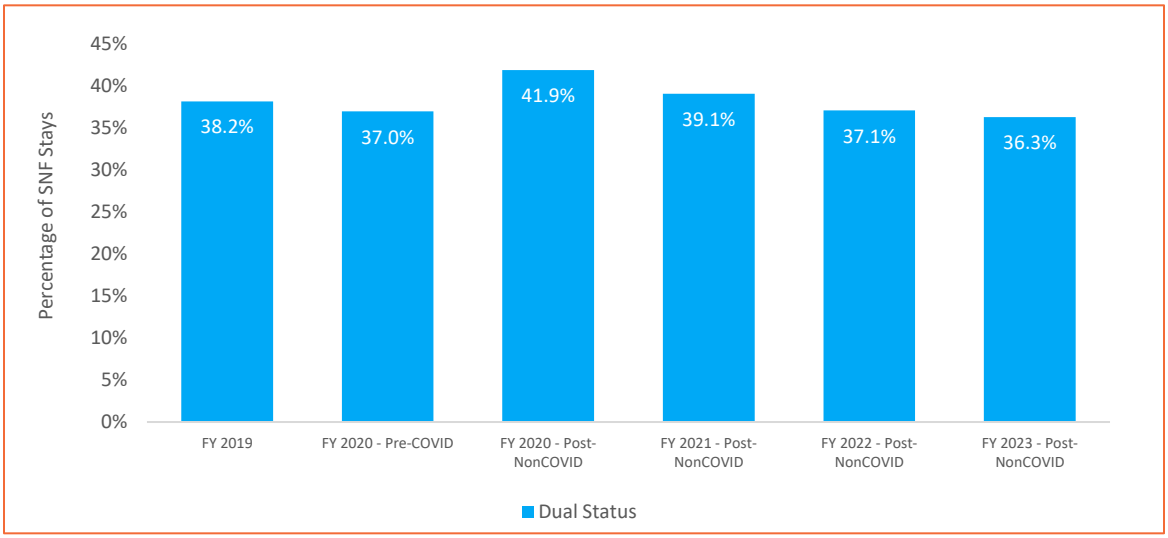


Source: Avalere analysis of 100% Medicare Claims Files Oct 2019 – Sept 2023

In the second half of FY 2020, a higher percentage of SNF stays were for beneficiaries dually eligible for Medicare and Medicaid services and for beneficiaries from lower income areas, compared to before the pandemic.

Dually eligible beneficiaries identified in this analysis were fully or partially eligible for both Medicaid and Medicare benefits during any month in the admission year. The percentage of SNF stays for dually eligible beneficiaries was 4.9 points higher in the second half of FY 2020 (41.9%) compared to the first half of 2020 (37%) (**Figure 24**). The percentage decreased to 37.1% in FY 2022 and 36.3% in FY 2023, aligning with pre-pandemic levels.

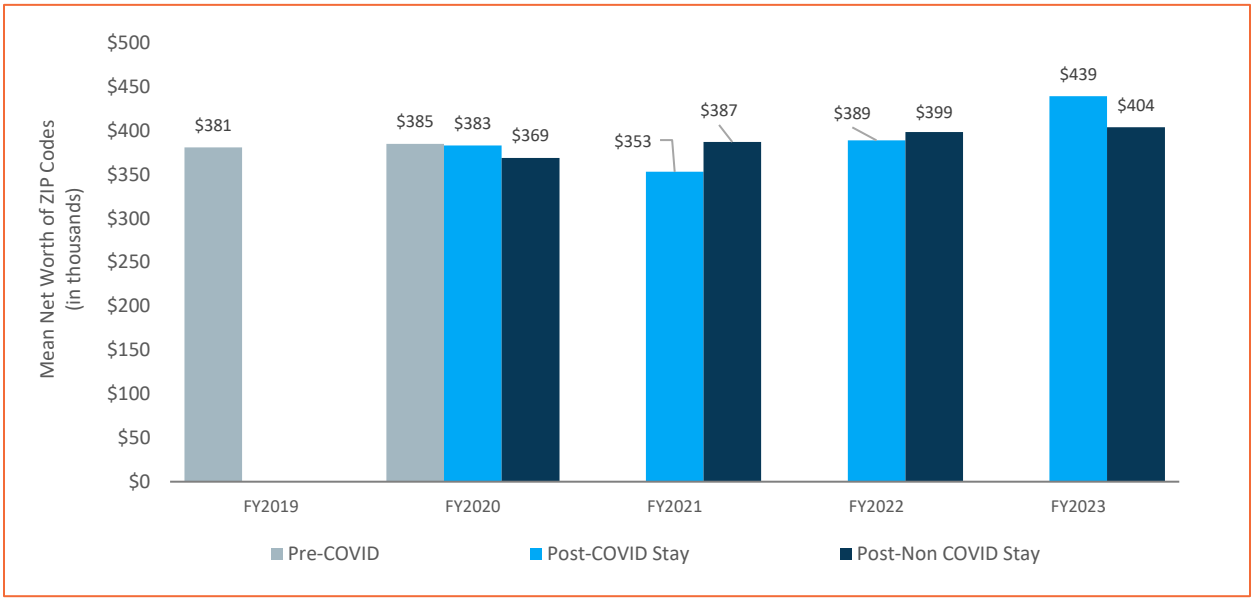
Figure 24: Dual Eligibility Status, SNF Stays, FY 2019 - FY 2023

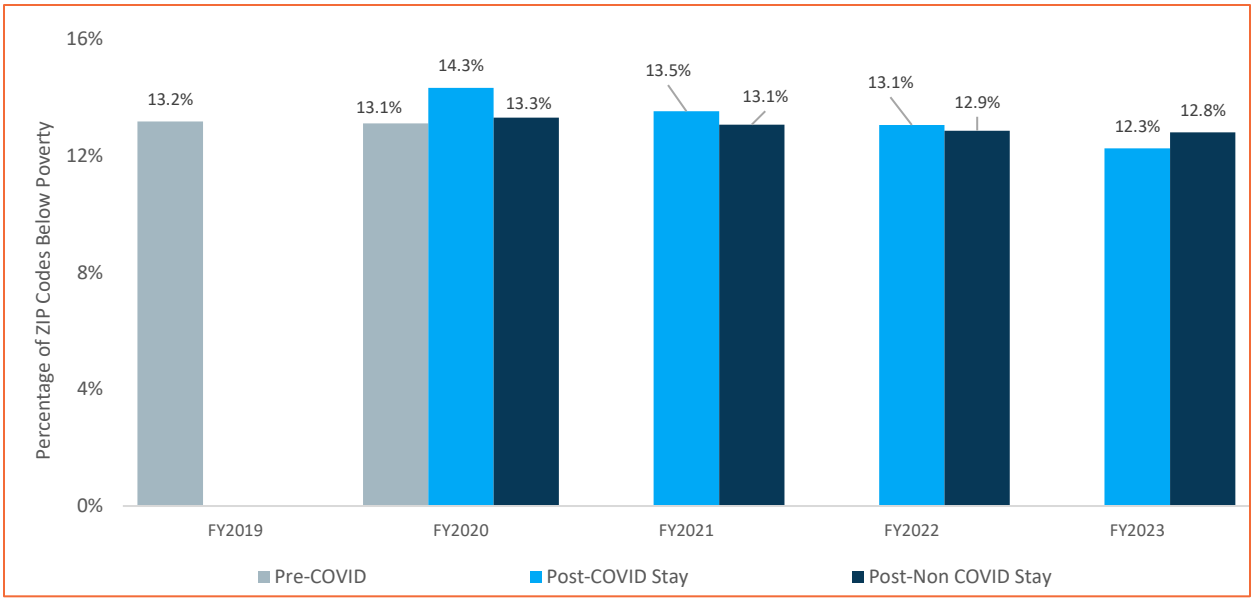


Source: Avalere analysis of 100% Medicare Claims Files Oct 2019 – Sept 2023

Avalere also examined changes in the characteristics of areas where SNF beneficiaries (with or without COVID-19) reside. After the onset of the pandemic in FY 2020, beneficiaries with a non-COVID SNF stay were from areas with lower average net worth compared to before the pandemic. During FY 2022 and FY 2023, SNF beneficiaries were from areas with higher average net worth pre-pandemic and in FY 2020 and FY 2021 (**Figure 25**). There was also a small increase in the percentage of SNF stays for beneficiaries admitted for a COVID-19 stay from areas below poverty after the pandemic started (**Figure 26**). SNF beneficiaries admitted for a non-COVID-19 stay residing in areas below poverty has remained constant.

Figures 25 and 26: Area of Residence Net Worth and Poverty Status, SNF Stays, FY 2019 - FY 2023

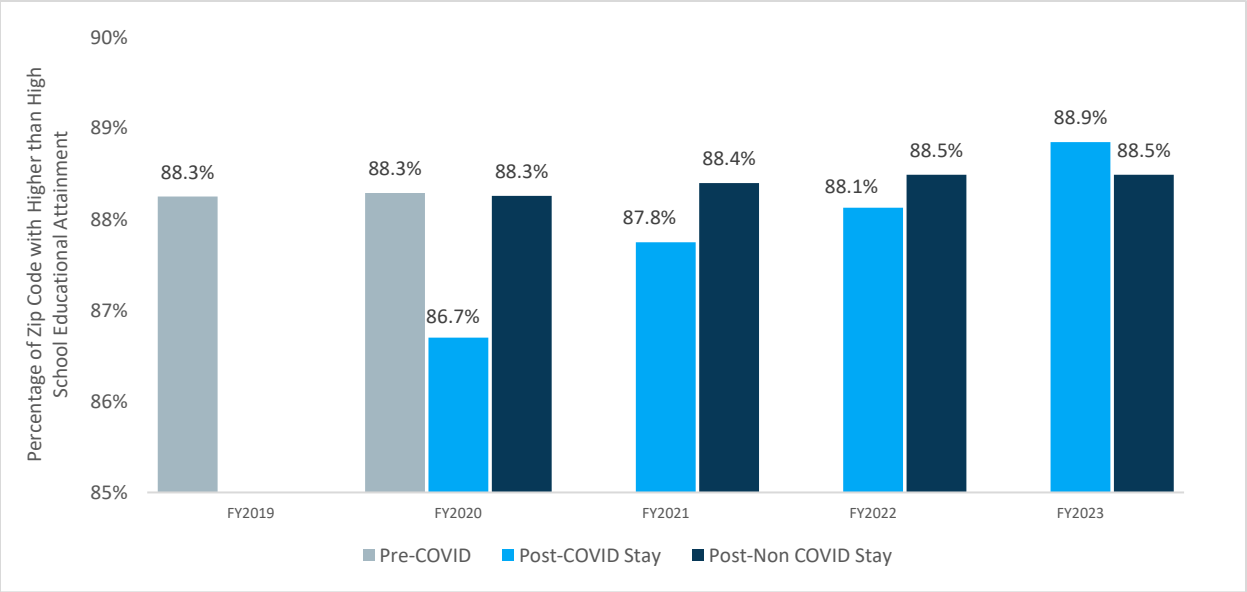


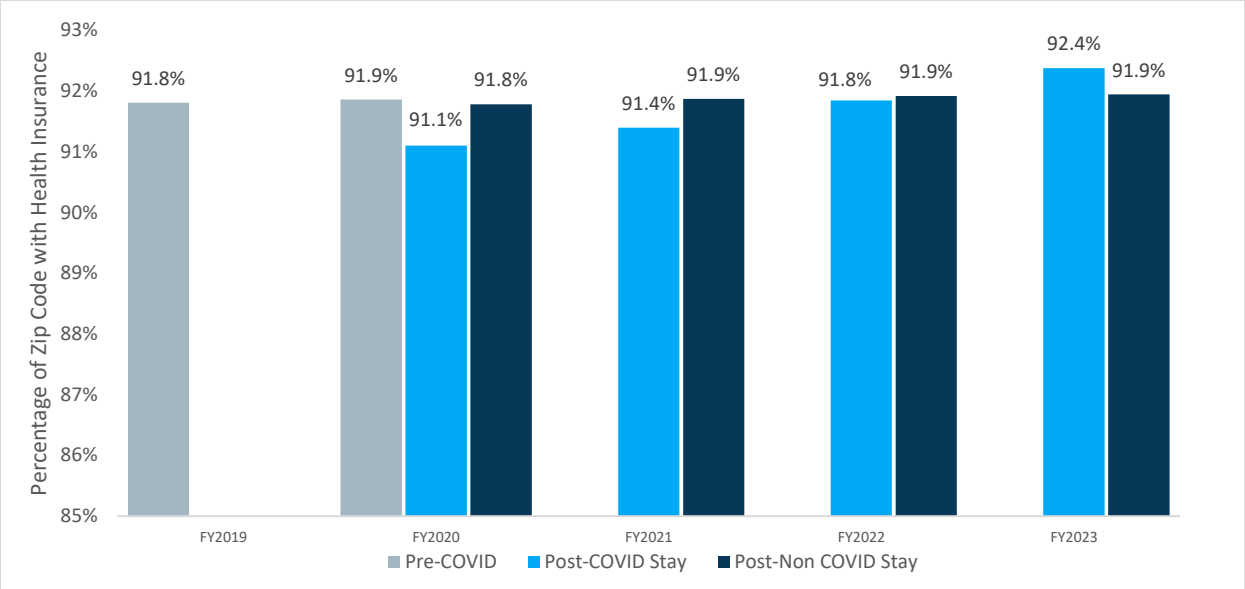


Source: Avalere analysis of Acxiom and ACS data Oct 2019 – Sept 2023

Avalere also examined two additional area characteristics of education and health insurance coverage. At the start of the pandemic in FY 2020, there were small decreases in the proportion of SNF stays occurring among beneficiaries from areas with higher educational attainment (**Figure 27**). The proportion of SNF stays from beneficiaries in areas with high rates of health insurance coverage (**Figure 28**) remained consistently above 91% from FY 2019- FY 2023.

Figures 27 and 28: Area of Residence Educational Attainment and Insurance Status, SNF Stays, FY 2019 - FY 2023

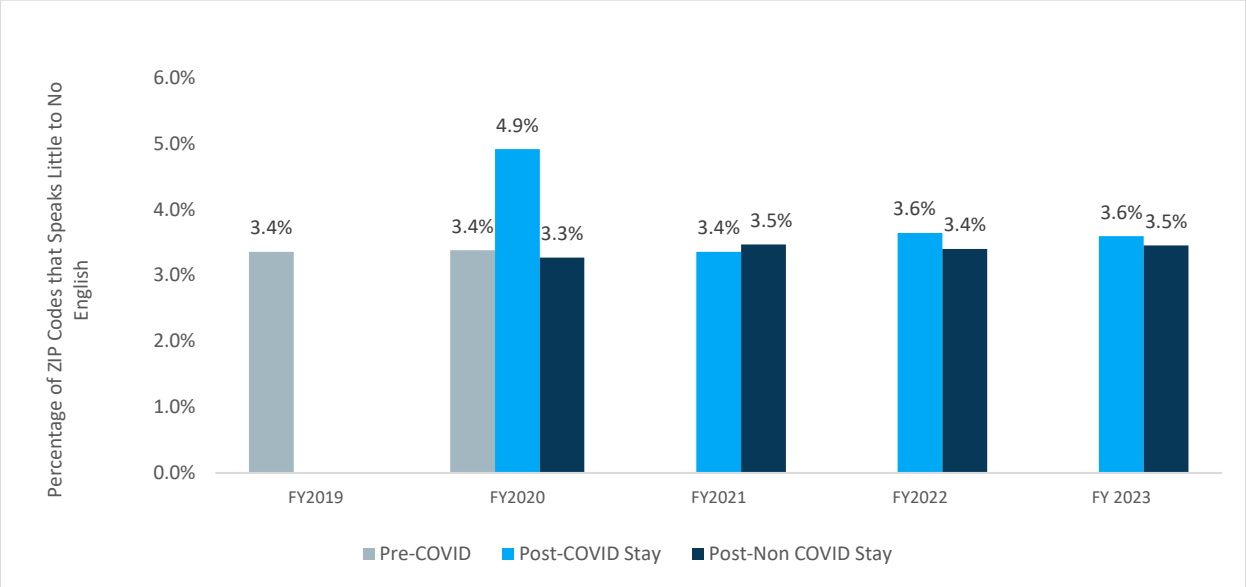




Source: Avalere analysis of Acxiom and ACS data Oct 2019 – Sept 2023

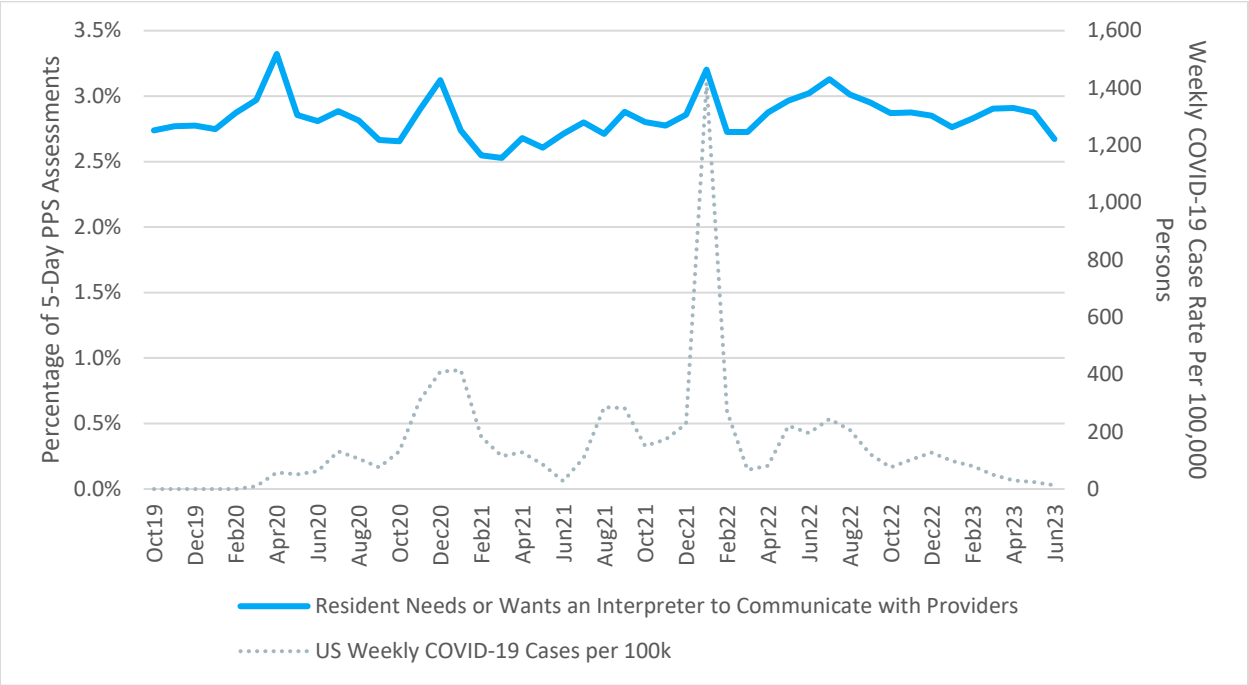
For language proficiency, Avalere found that there was a 1.5-percentage point increase between the first and second half of FY 2020 in the percentage of SNF stays for beneficiaries diagnosed with COVID-19 from areas where residents speak little to no English (**Figure 29**). The percentage of MDS 5-day assessments where residents needed or wanted an interpreter peaked at the start of the pandemic as well as during subsequent COVID-19 surges in January 2021, January 2022, and summer 2022 (**Figure 30**).

Figure 29: Area of Residence Speaking Little to No English, SNF Stays, FY 2019 - FY 2023



Source: Avalere analysis of Acxiom and ACS data Oct 2019 – Sept 2023

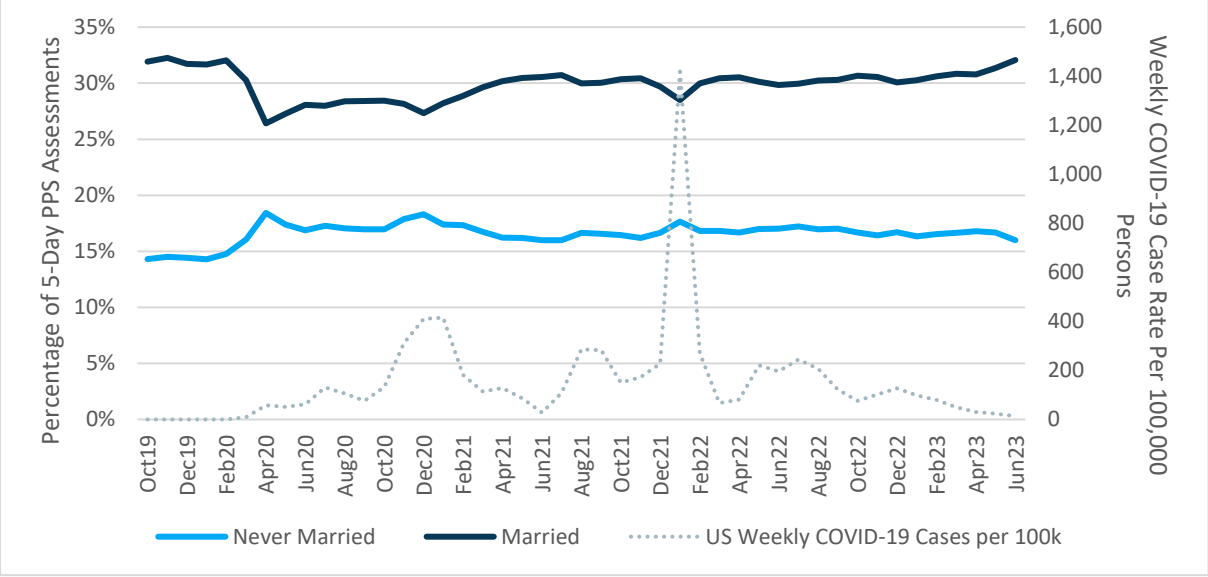
Figure 30: Language Needs, SNF MDS 5-Day Assessments, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

The SNF MDS 5-day assessments were also used to analyze marital status among beneficiaries using SNFs. At the start of the pandemic, the percentage of 5-day assessments where beneficiaries were noted as married decreased, with a corresponding increase in the percentage of assessments for beneficiaries who were never married (**Figure 31**). Similar fluctuations aligned with COVID-19 surges in January 2021 and January 2022.

Figure 31: Marital Status, SNF MDS 5-Day Assessments, Oct 2019 – Jun 2023



Source: Avalere analysis of MDS data Oct 2019 – Jun 2023

Coding Pattern Changes for Depression and Speech Language Pathology (SLP) 2019-June 2023

With the introduction of the Patient Driven Patient Model (PDPM) in FY 2020, providers have faced significant changes to the way Medicare payments are established. Avalere performed claims analyses specific to depression and speech language pathology diagnoses coding to learn more about potential changes in coding patterns for these items over 2019 through June 2023.

Methods

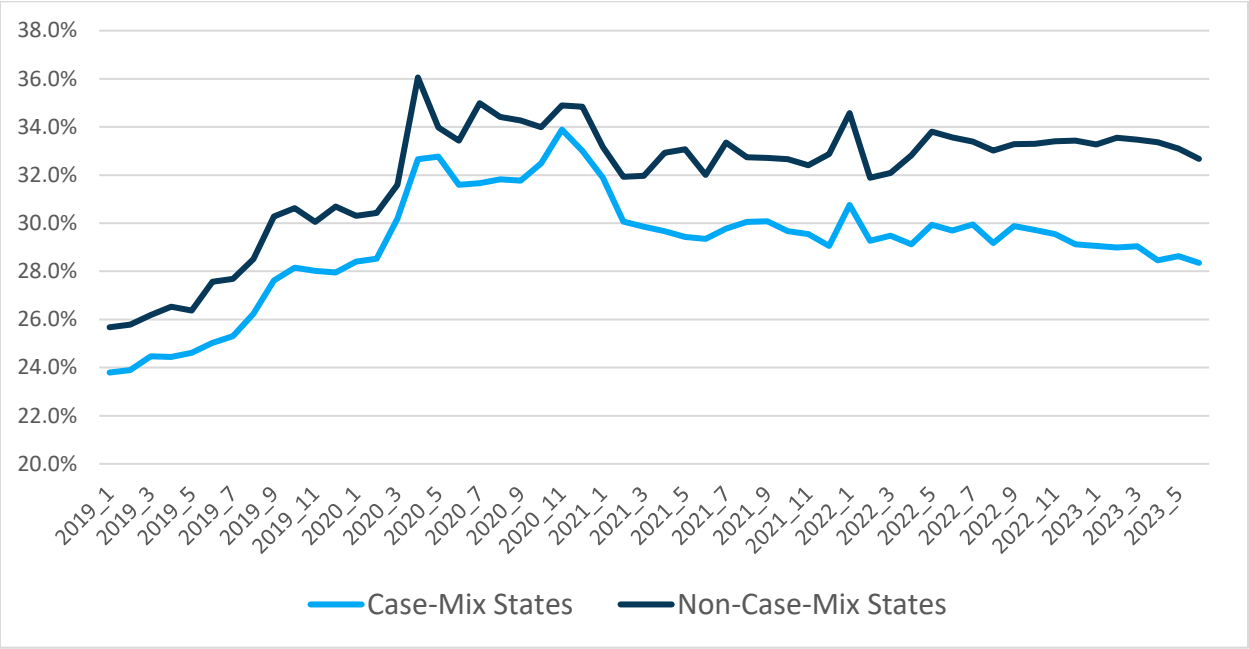
Avalere identified SNF claims using 100% Medicare standard analytic files (SAFs) from January 1, 2019 to June 30, 2023. Diagnosis of depression was defined based on the Centers for Medicare & Medicaid Services (CMS) Chronic Condition Warehouse file and SLP comorbidities were identified using the PDPM ICD-10 mappings published by CMS. Analyses were stratified by case-mix and non-case-mix states based on assignment from the Medicaid and CHIP Payment and Access Commission (MACPAC).[3] Note that SNF stays coded as waiver with a prior inpatient stay of 3 days or more were included in the analyses as these reflect qualifying Medicare SNF stays under current law.

Results

The proportion of days with a diagnosis for depression increased slightly at the transition to the PDPM in FY 2020 and increased again during the first year of the COVID-19 pandemic (**Figure 32**). The proportion of days with a diagnosis for depression returned closer to pre-pandemic levels in 2022 and into 2023. Overall patterns of change were similar across case-mix and non-case-mix states though non-case-mix states have a higher percentage of days for claims with a depression diagnosis.

[3] MACPAC. "States' Medicaid Fee-for-Service Nursing Facility Payment Policies," October 2019. Available here.

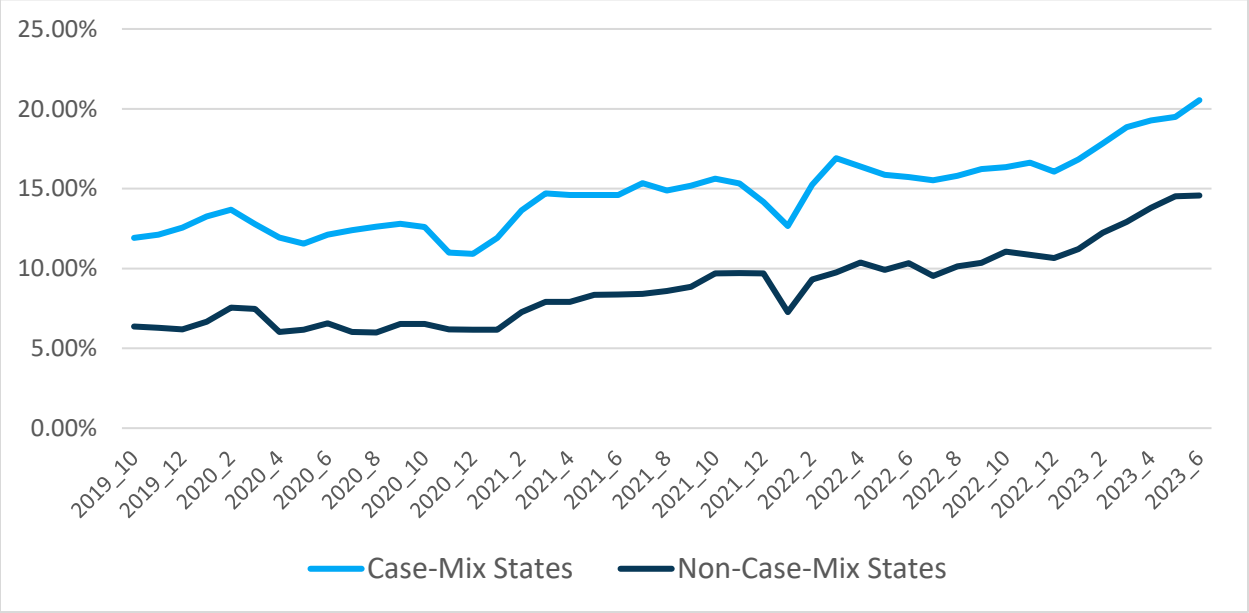
Figure 32: Percentage of Days with a Depression Claim Diagnosis, 2019 – June 2023



Source: Avalere analysis of 100% Medicare Claims Files Jan 2019 – June 2023

The proportion of days with a case mix group (CMG) assigned based on depression was relatively stable for the first year of the PDPM and has increased slightly since 2021 (**Figure 33**).

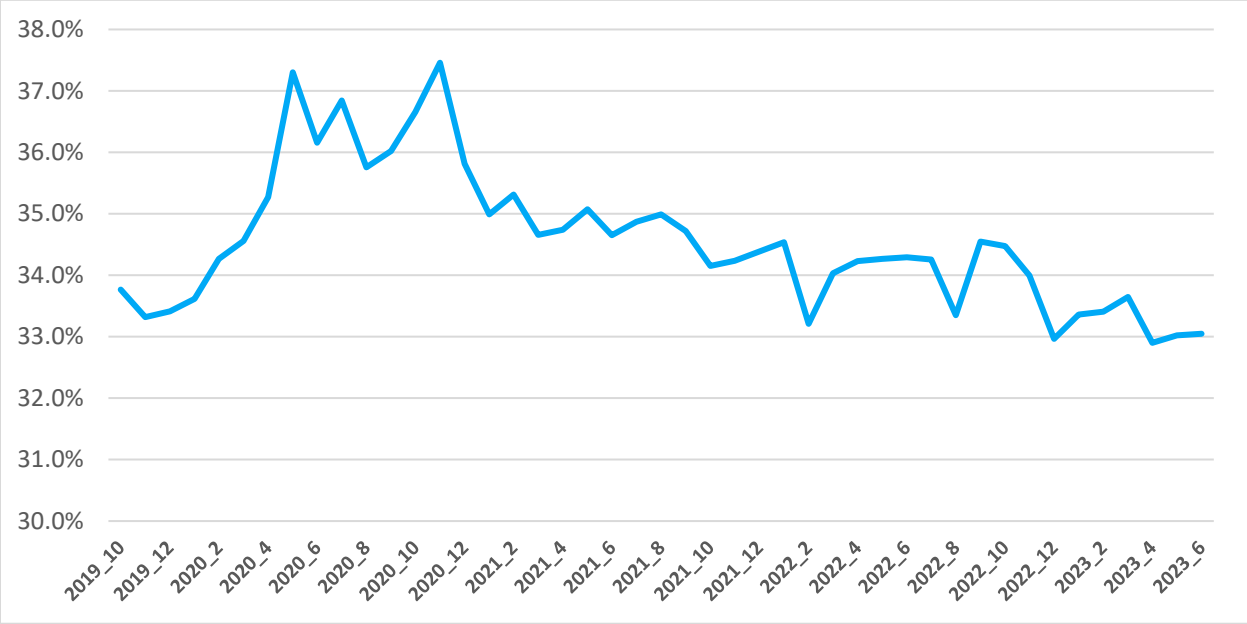
Figure 33: Percentage of Days with a CMG Assigned Based on Depression, 2019 – June 2023



Source: Avalere analysis of 100% Medicare Claims Files Jan 2019 – June 2023

The proportion of claims with a CMG assigned based on depression that also had a claim with a diagnosis for depression rose at the start of the COVID-19 pandemic and has decreased since 2021 (**Figure 34**).

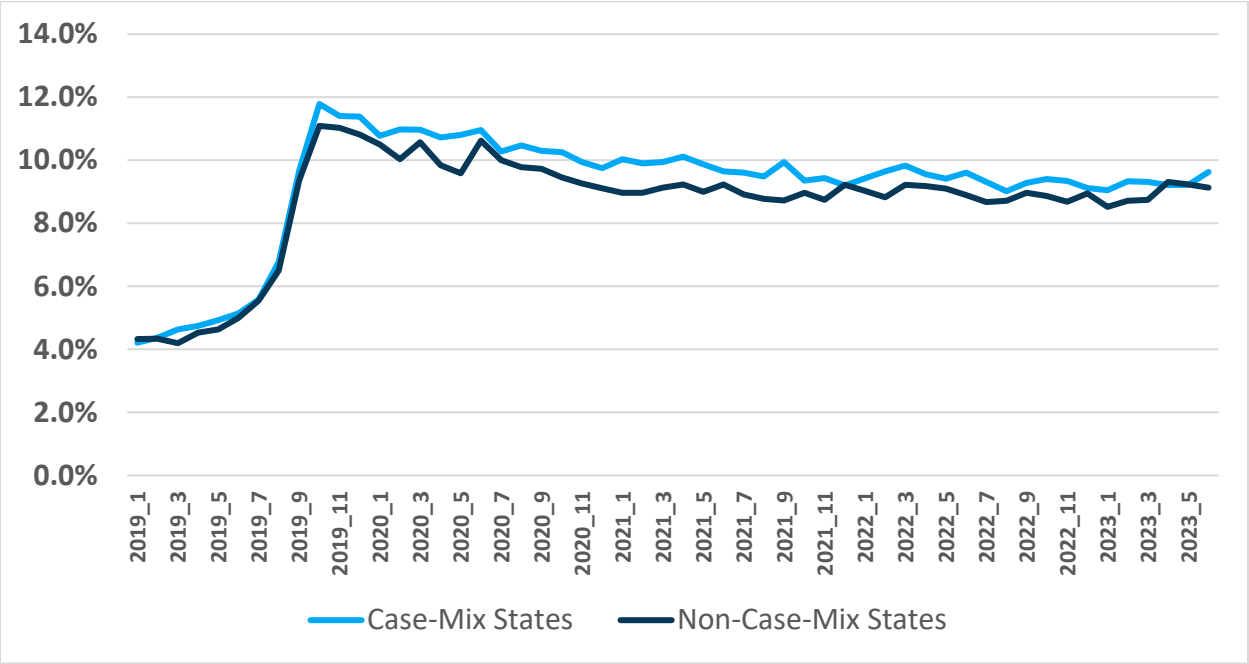
Figure 34: Percentage of Claims with a CMG Assigned Based on Depression with a Claim ICD-10 Code for Depression, 2019 – June 2023



Source: Avalere analysis of 100% Medicare Claims Files Jan 2019 – June 2023

The proportion of days with a diagnosis for a SLP comorbidity increased significantly at the transition to the PDPM in FY 2020 and remained high through June 2023 (**Figure 35**). Assignment to these categories was based on ICD-10 coding on claims ICD-10 mappings from CMS.

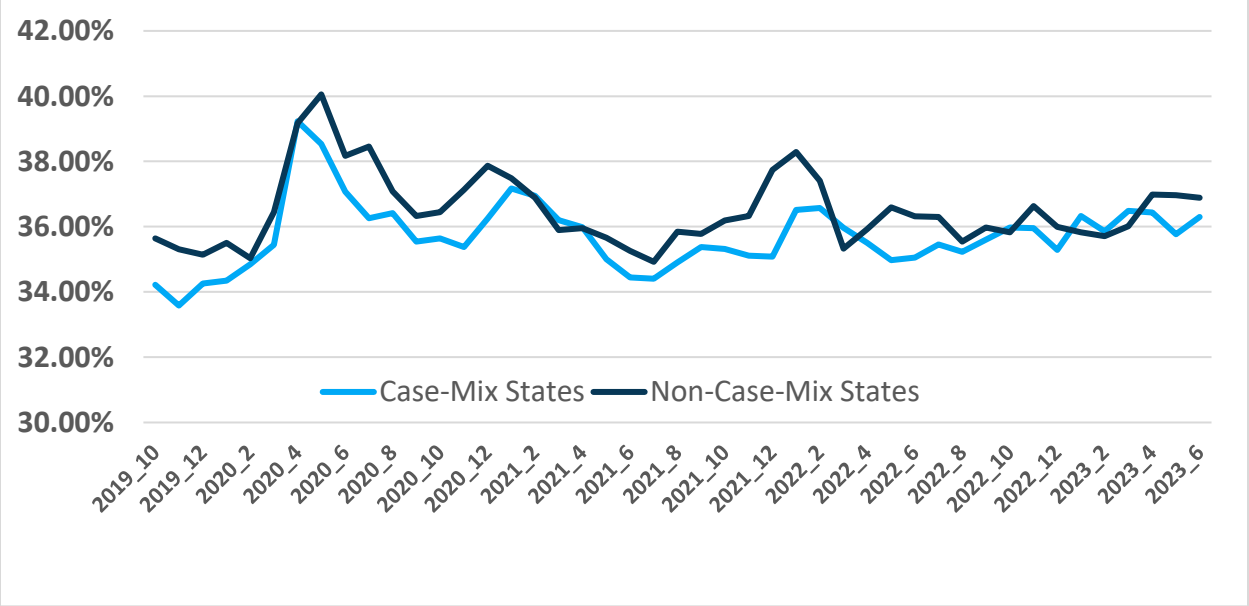
Figure 35: Percentage of Days Claim Diagnosis for a SLP Comorbidity, 2019 – June 2023



Source: Avalere analysis of 100% Medicare Claims Files Jan 2019 – June 2023

The proportion of days with a CMG assigned based on either a mechanically altered diet or swallowing disorder rose at the start of the COVID-19 pandemic and then generally decreased though there was an increase in late 2021 corresponding to a surge in COVID-19 cases. (**Figure 36**).

Figure 36: Percentage of Days CMG Assigned Based on a Mechanically Altered Diet or Swallowing Disorder, 2019 – 2021



Source: Avalere analysis of 100% Medicare Claims Files Jan 2019 – Dec 2021

Conclusion

The results presented here indicate that even after removing SNF stays with a COVD-19 diagnosis and stays admitted through the waiver of the 3-day stay rule, there were changes in the characteristics of beneficiaries treated in SNFs over the course of the COVID-19 pandemic. These changes were observed in both medical complexity and severity of illness and in demographics and social determinants of health. These changes are important to understand both in the context of the transition to the PDPM and in the context of changing health care utilization patterns post COVID-19 pandemic.