June 5, 2023

Re: Medicare and Medicaid Programs; 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 2024, CMS – 1779-P

Submitted electronically, https://www.regulations.gov

Dear CMS Colleagues:

National Consumer Voice for Quality Long-Term Care (Consumer Voice) submits the following comments on the April 10, 2023, Notice of Proposed Rule Making (NPRM). (88 Fed. Reg. 21316).

National Consumer Voice for Quality Long-Term Care (Consumer Voice) is a national non-profit organization that advocates on behalf of long-term care consumers across care settings. Our membership consists primarily of consumers of long-term care services, their families, long-term care ombudsmen, individual advocates, and citizen advocacy groups. Consumer Voice has more than 40 years of experience advocating for quality nursing home care.

While we offer detailed comments below, we want to emphasize our strong opposition to the Center for Medicare & Medicaid Services' (CMS) proposal to adopt the CoreQ measure as part of its Skilled Nursing Facility Quality Reporting Program (QRP). While Consumer Voice does support directly measuring resident satisfaction, we oppose the use of CoreQ, a measure developed by and for the nursing home industry. The measure is biased toward positive reviews, is too vague, and excludes too many residents. We offer more detailed comments below, but we urge CMS to reconsider its decision to use this measure.

Below you will find select responses to the Notice of Proposed Rulemaking.

I.   General Statement on the PPS System

 A. CMS Must Increase Cost Reporting Requirements and Audit Cost Reports

In February 2022, President Biden announced a historic set of nursing home reforms. One of the cornerstones of these reforms was increased transparency of nursing home ownership and finances. While CMS has taken steps to address transparency in nursing home ownership, we are concerned that CMS has not taken action to address accountability for how nursing homes spend Medicare and Medicaid dollars. In March 2023, Consumer Voice released a report, "Where Do the Billions of Dollars Go? A Look at Nursing Home Related Party Transactions,"[1] in which we documented how billions of dollars are funneled through related party organizations with little to no scrutiny from CMS. In the report, we called for increased disclosure requirements on Medicare cost reports and for CMS to audit these reports.

The Medicare Prospective Payment System (PPP) pays for nursing homes based on the acuity level of residents, yet CMS does little to ensure that this care is provided. In 2016, the Government Accountability Office (GAO) recommended CMS take steps to increase scrutiny on cost report data to ensure its reliability.[2] CMS should be auditing cost reports not only to confirm they are accurate, but to hold facilities accountable for how they use Medicare and Medicaid dollars.

We urge CMS to increase accountability for how nursing homes spend the billions of taxpayer dollars they receive each year by requiring increased disclosure on Medicare cost reports and heightened scrutiny of how this money is spent.

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[1] https://theconsumervoice.org/uploads/files/issues/2023-Related-Party-Report.pdf.
[2] U.S. Government Accountability Office (US GAO). Skilled nursing facilities: CMS should improve accessibility and reliability of expenditure data. GAO-16-700. Washington, D.C.: GAO, September 2016.

Proposed Modification of the COVID-19 Vaccination Coverage among Healthcare
Personnel (HCP) Measure Beginning with the FY 2025 SNF QRP (p. 21333)

We support the continued monitoring of vaccination and booster status of nursing home staff. As the NPRM makes clear, COVID-19 vaccinations and boosters have saved the lives of countless nursing home residents and workers. However, we are deeply concerned about CMS's recent announcement that it would no longer require nursing home staff to be vaccinated or boosted against COVID-19. The most effective protection against COVID-19 has been vaccines and boosters. Yet CMS has decided to remove this vital protection from nursing home residents. We urge CMS to reconsider this decision.

Because CMS is no longer requiring nursing home staff to be vaccinated, this monitoring measure becomes even more critical. Nursing home residents and their families will need up-to-date information on facility vaccination and booster levels to make informed health care decisions.

Proposed Adoption of the CoreQ: Short Stay Discharge Measure (NQF#2614) Beginning with the FY 2026 SNF QRP (p. 21344)

When CMS proposed using the CoreQ: Short Discharge Measure in 2022, Consumer Voice strongly opposed[3] its adoption. We restate our opposition and urge CMS to reconsider using this measure. The CoreQ measure was created by the American Healthcare Association, an organization that lobbies on behalf of for-profit nursing homes. The measure is biased toward positive reviews, excludes many residents from the denominator, and is oversimplified. Rather than using a satisfaction measure created by and for the nursing home industry, we urge CMS to adopt a more balanced/comprehensive measure, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS).

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[3] https://theconsumervoice.org/uploads/files/issues/CV_RFI_Responses_6.10.22.pdf

There are only four questions in the CoreQ measures. They are vague, leading, and inexact. Our concerns about each question follow.

1. In recommending this facility to your friends and family, how would you rate it overall?

   The Merriam-Webster Dictionary contains the following definitions for "recommend":

   - To present as worthy of acceptant or trial
   - To endorse as fit, worthy, or competent
   - Entrust, commit.
   - To make acceptable
   - To suggest an act or course of action.

   "Recommend" is a word that denotes endorsement, agreement, or preference. In essence, the first question suggests to residents that they should provide positive feedback to friends and family about a facility. It will seem bizarre to residents to suggest they recommend a facility to friends or family but give it a "Poor" rating. This question is therefore biased toward positive reviews for the facility.

2. Overall, how would you rate the staff?

   This question is too vague to be of any use in assessing quality. A plethora of different types of staff work in nursing homes, including direct care staff, social workers, food service professionals, janitors, and general laborers. This question fails to differentiate between the varying importance of different staff types. Certainly, residents may feel differently about direct care staff than they do about food service workers or other departments, but this question groups all staff together, making it impossible to ascertain which staff a resident is assessing.

   Additionally, what are the criteria by which the residents are supposed to be evaluating staff? Friendliness? Responsiveness? Professionalism?

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Competency? Some residents may have really liked their CNA, despite the fact the CNA was unresponsive due to being overworked. Additionally, it is unclear what "overall" means. "Overall" implies there is some subset of ratings the resident is using to provide an "overall" rating. Which factors are residents supposed to consider when providing an "overall" rating? The measure provides no guidance to residents, therefore allowing them to assign their own meaning to the questions, which will make their responses useless to CMS and consumers.

3. How would you rate the care you received?

Again, this question is too vague. What is "care"? Is it food service? Is it transferring? What should residents be using as a benchmark against which to compare their "care"? The term "care" is far too ambiguous. Residents could have received terrific care from a CNA, but inadequate care from a skilled therapist, or vice versa. How do they balance that experience? Most importantly, people relying on these reviews, including CMS, will have no idea what "care" respondents are referring to. To have one rating for every type of care makes the rating of little use, because it does not account for the fact that residents receive a variety of "care" during their stays at nursing home facilities.

4. How would you rate how well your discharge needs are met?

How is a resident to know how their discharge needs were met? Most residents will not be made aware of their discharge rights and protections under the Nursing Home Reform Act of 1987. Residents are often told they have to leave. Further, some residents may have higher-than-required expectations for discharge, for which this question cannot account. What does CMS hope to gain from this information, when it is completely unclear what the residents' expectations were?

There are five potential responses, only one of which is negative (Poor). In other words, 80% of the residents' options provide feedback that indicates a

facility is average or better. The measure excludes a neutral middle, which is common in a five-point scale.

What does "average" mean? How many nursing homes must a resident have been in to determine whether the care they received was "average"? Many nursing home residents will never have been in a facility before and will have no idea if the care they received was "average." Additionally, by using the term "average" as a choice, the other choices refer to it. Good, Very Good, and Excellent must all be better than average under this scoring system. They are all relative to the term average, yet most residents will have no idea what "average" care in a nursing home is. Similar to the questions, the scoring uses terms so unclear and relative that they capture only meaningless results.

The measure excludes far too many residents, particularly residents who may have been dissatisfied with the care they received. The measure excludes residents who transfer to another nursing home, a psychiatric facility, an inpatient rehabilitation facility, or a long-term care hospital. It is not clear why the measure excludes these residents. Residents who choose to go to another facility may do so because they are dissatisfied with the care they are receiving. If care is so poor in a facility that residents transfer to another facility, other consumers would want to have that information. Additionally, the measure excludes residents who leave a facility against medical advice.

The measure also excludes residents with dementia. This exclusion is impermissible. CMS and the public have a significant interest in assessing the care quality provided to residents with dementia. Impermissible drugging of residents with dementia and the use of restraints is a problem acknowledged by CMS, yet CMS is proposing a measure to gauge resident satisfaction that will exclude all residents with dementia. The ability for residents with dementia to respond to surveys is certainly a concern, but steps can be taken to ensure these residents' voices are heard.

Importantly, the in April 2022, the National Academy of Sciences, Engineering, and Medicine issued a report, "The National Imperative to Improve Nursing

Home Quality," which specifically did not endorse the CoreQ measure.[4] In fact, the report noted that the CoreQ measure "focus[ed] less on rating the quality of resident experience and more on summative satisfaction ratings."[5] The report did not endorse the CoreQ measure, but instead recommended the use of the CAHPS survey, which was developed by the Agency for Healthcare Research and Quality, in conjunction with CMS.[6]

CMS has proposed a measure that is so simple it tells us almost nothing about the resident's experience. It asks leading questions, employs vague and undefined terms which will result in meaningless results to CMS and others hoping to rely on these surveys. While the simplicity of the CoreQ measure has been emphasized in its favor, Consumer Voice believes it is its fatal flaw. The importance of gauging resident satisfaction is undeniable, but we urge CMS to adopt a more comprehensive measure, such as CAHPS, and not the CoreQ measure.

Principles for Selecting and Prioritizing SNF QRP QMS and Concepts Under Consideration for Future Years (RFI) (p. 21353)

Consumer Voice supports assessing quality in nursing homes. However, in general, we oppose CMS's reliance on data that nursing facilities self-report to the federal government. A recent study compared Medicare claims data to the Minimum Data Set (MDS) and found that nursing homes under-report falls that result in hospitalizations by roughly 40%[7]. The study also found that pressure ulcers were under-reported by 32%.[8] Consumer Voice has drawn attention[9] to the vast disconnect between quality measure based on self-

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[4] National Academy of Sciences, Engineering and Medicine, *The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff*, p. 111 (2022)
[5] Id.
[6] Id.
[7] Sanghavi P, Chen Z. Underreporting of Quality Measures and Associated Facility Characteristics and Racial Disparities in US Nursing Home Ratings. *JAMA Netw Open.* 2023;6(5):e2314822. doi:10.1001/jamanetworkopen.2023.14822
[8] Id.
[9] https://theconsumervoice.org/uploads/files/actions-and-news-updates/Using_the_Five_Star_Quality_Measure_to_Mask_Bad_Care.pdf

reported data and more reliable data, such as the Payroll Based Journal (PBJ) or state surveys. Our report found that 36% of facilities with a five-star Quality Measure Rating have a 1- or 2-star rating in staffing.[10] This disparity between reliable third-party data and self-reported data by facilities indicates that CMS must create measures that do not rely on MDS data but on other data, such as PBJ, Medicare claims data, state surveys, or other more objective measures. A failure to do so continues to call into question the reliability of current and future measures, which renders them of limited use to consumers and their families.

Proposal to Increase the SNF QRP Data Completion Thresholds for MDS Data Items Beginning With the FY 2026 SNF QRP (p. 21360)

We support increasing the completion requirement for MDS data submitted to CMS, but we believe CMS should require facilities to complete 100% of the data on 100% of data submissions. For years, CMS has allowed nursing homes to only submit 100% of data on 80% of data submissions. This practice allows the gaming of the system and the omission of data that may reflect poorly on a facility. Now CMS proposes to raise the completion rate to 90%. This percentage increase is not enough. Nursing homes are professional health facilities that should be providing accurate data on all residents. Allowing 10% of data to be omitted is highly problematic and will continue to allow facilities to omit data that could be unfavorable to them.

Proposal to Adopt the Total Nursing Staff Turnover Measure Beginning with the FY 2026 SNF VBP Program Year (p. 21366)

Consumer Voice strongly supports the adoption of the Total Nursing Staff Turnover Measure. CMS's recent focus on staff turnover has been strongly endorsed by Consumer Voice. CMS now posts turnover data for every nursing home in the United States. Staff turnover is a barometer of job quality and care quality.

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[10] Id.

The inclusion of this measure will incentivize facilities to invest in staff wages, benefits, and training in order to reduce turnover. Consumer Voice applauds CMS for including this measure in the Value Based Purchasing Program.

Proposal To Adopt the Percent of Residents Experiencing One or More Falls with Major Injury (Long-Stay) Measure Beginning With the FY 2027 SNF VBP Program Year (p. 21368)

Consumer Voice supports developing a measure for falls with major injury, only if it relies on Medicare claims data. As proposed, CMS plans to use MDS data to implement this measure, which Consumer Voice opposes, because the data is inaccurate and unreliable. A recent study found that nursing homes under-report falls by nearly 40%.[11]

Another study conducted in 2019 found that only 57.5% of residents with major injury falls that were identified through Medicare claims data had these falls reported in their MDS data.[12] The study also found that:

- More falls were reported on MDS for long-stay residents (62.9%) than for short-stay residents (47.2%).
- More falls were reported on MDS for white residents (59.0%) than for nonwhite residents (46.4%).
- Long-stay white residents had the highest reporting rate (64.5%), while short-stay nonwhite residents had the lowest reporting rate (37.4%).

Because these studies show the serious unreliability of MDS data, we urge CMS to use Medicare claims data when adopting this measure. We oppose the adoption of this measure, if it uses MDS data as the measure's data source.

Proposal to Incorporate Health Equity into the SNF VBP Program Scoring Methodology Beginning with the FY 2027 Program Year (p. 21384)

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[11] Sanghavi P, Chen Z. Underreporting of Quality Measures and Associated Facility Characteristics and Racial Disparities in US Nursing Home Ratings. *JAMA Netw Open.* 2023;6(5):e2314822. doi:10.1001/jamanetworkopen.2023.14822

[12] Sanghav, P., Pan, S., and Caudry, D. Assessment of SNF reporting of major injury falls for quality measurement on SNF compare. *Health Services Research*, p. 5. 2019; 00:1-10. https://doi.org/10.1111/1475-6773.13247

Consumer Voices thanks CMS for proposing to address inequities in health care by employing a scoring methodology that rewards facilities that serve more dual-eligible residents. However, we also urge CMS to increase scrutiny on how these nursing facilities spend their current Medicare and Medicaid dollars. CMS must understand the problems facing these homes, while at the same time incentivizing better care.

CMS could also address inequities related to race and ethnicity by making facility level data on race and ethnicity available to the public. Currently, CMS does not provide this data, which results in researchers and the public having to rely on geographic assumptions when assessing racial and ethnic disparities in care. CMS should make this data available to researchers and the public to address these inequities head on.

Proposal To Adopt a Validation Process That Applies to SNF VBP Measures That Are Calculated Using MDS Data (p. 21398)

We support CMS's proposal to adopt a validation process for VBP measures that rely on MDS data. As we have repeatedly noted throughout our comments, MDS data is unreliable and inaccurate. In order for the QRP and VBP measures that rely on MDS data to be effective, CMS must scrutinize the MDS data. Without auditing and validating MDS data, there can be little confidence in the self-reported data. We urge CMS to implement strict and system-wide validation processes that provide for penalties when nursing facilities fail to submit MDS data or submit erroneous or incomplete data. These penalties should not apply solely to the VBP validation process, but to the QRP program as well.

Civil Money Penalties: Waiver of Hearing, Automatic Reduction of Penalty Amount (p. 21400)

Consumer Voice opposes CMS's proposal to deem a facility has waived its right to a hearing if it does not timely request it. Currently, a facility must waive this right in writing for it to take advantage of the 35% reduction in the civil monetary penalty (CMP) amount. CMS now proposes to lift that requirement.

CMS justifies this change, in part, by stating it reduces the financial burden on facilities that have violated nursing home regulations and are facing monetary penalties. The financial repercussions facilities may face for violating regulations incentivize better care. Eliminating the requirement that facilities waive their rights removes an incentive for facilities to comply with the regulations. It is unclear why CMS is concerned about the administrative burden on facilities who are admitting, in writing, that they have violated the regulations and are subject to a CMP. We urge CMS not to forfeit an important enforcement tool and to rescind this proposal.

Thank you for your consideration.

Sincerely,

Samuel Brooks
Director of Public Poliocy