

Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

June 3, 2021

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

Dear CMS Administrator Brooks-LaSure and CMS Colleagues:

The Center for Medicare Advocacy (Center) submits comments on proposed rules to update Medicare reimbursement for skilled nursing facilities (SNFs), published on April 15, 2021 at 71 Reg. 19954. The National Consumer Voice for Quality Long-Term Care (Consumer Voice) joins in these comments.

The Center for Medicare Advocacy (Center) is a national, private, non-profit law organization, founded in 1986, that provides education, analysis, advocacy, and legal assistance to assist people nationwide, primarily the elderly and people with disabilities, to obtain necessary health care, therapy, and Medicare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care and provides training regarding Medicare and health care rights throughout the country. It advocates on behalf of beneficiaries in administrative and legislative forums, and serves as legal counsel in litigation of importance to Medicare beneficiaries and others seeking health coverage. These comments are based on our experiences talking with and representing thousands of Medicare beneficiaries and their families.

The National Consumer Voice for Quality Long-Term Care (Consumer Voice) is a national nonprofit consumer advocacy organization founded in 1975 due to public concern about substandard care in nursing facilities. The Consumer Voice is the leading national voice representing consumers in issues relating to long-term care and is the primary source of information and tools for consumers, families, caregivers, ombudsmen, and other advocates to help ensure quality care for all residents. Consumer Voice is dedicated to advocating for quality care, quality of life, and protection of rights for all individuals receiving long-term care, services, and supports.

**Before discussing specific provisions of the proposed rule, the Center and Consumer Voice raise issues about CMS's significant and unwarranted deference to the nursing home industry.** CMS expresses concern about immediately recalibrating Medicare rates because of concern about provider finances and also, in its discussion of the Value-Based Purchasing Program, about not penalizing facilities for poor resident outcomes that were distorted by the pandemic.

First, providers' finances are not as dire as the nursing home industry claims when it seeks more money. An analysis by David E. Kingsley and Charlene Harrington, "COVID-19 had little

financial impact on publicly traded nursing home companies,”<sup>1</sup> documents that nine of 11 publicly traded companies that it reviewed “reported higher net incomes in 2020 compared to 2019.” They found “the cash-related metrics reported by publicly listed companies including the REITS, except for three companies, improved in 2020 in relation to 2019.”

The Medicare Payment Advisory Commission (MedPAC) reports in March 2021, as it has reported annually for more than two decades, that SNFs’ margins under Medicare exceed 10%.<sup>2</sup> MedPAC issued the unanimous recommendation of its members that CMS “eliminate the update to the 2021 Medicare base payment rates for skilled nursing facilities.”<sup>3</sup>

In May 2021, the trade press *Skilled Nursing News* reported the “‘voracious appetite’ for skilled nursing facilities” among private company buyers<sup>4</sup> and finds that prices per bed rose nearly 22% from 2020 to the first quarter of 2021, “reaching the second-highest price point for the sector ever recorded.”<sup>5</sup> The average price per bed is now \$90,700. *Skilled Nursing News* attributes facilities’ financial performance during the COVID-19 pandemic to the \$100 billion given to facilities under the CARES Act and the \$4.9 billion from the Department of Health and Human Services.

Second, the nursing home industry has responsibility for the COVID-19 cases and deaths among residents and staff. While some spread of COVID-19 early in the pandemic reflected the lack of understanding about asymptomatic spread of the virus and other COVID-19-specific issues, later cases reflect longstanding failures of facilities to maintain adequate staffing levels and to implement appropriate practices to address infection control. Multiple media stories and research articles<sup>6</sup> as well as the New York State Attorney General<sup>7</sup> document the importance of staffing and the correlation of COVID-19 cases and deaths with insufficient numbers of nursing staff.

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<sup>1</sup> Kingsley DE, Harrington C. COVID-19 had little financial impact on publicly traded nursing home companies. *J Am Geriatr Soc.* 2021;1–4. <https://doi.org/10.1111/jgs.17288>

<sup>2</sup> Medicare Payment Advisory Commission, *Report to the Congress : Medicare Payment Policy*, p. 199 (Mar. 2021), [http://medpac.gov/docs/default-source/reports/mar21\\_medpac\\_report\\_to\\_the\\_congress\\_sec.pdf?sfvrsn=0](http://medpac.gov/docs/default-source/reports/mar21_medpac_report_to_the_congress_sec.pdf?sfvrsn=0)

<sup>3</sup> *Id.* 196

<sup>4</sup> Amy Stulick, “Buyers Have ‘Voracious Appetite’ for Skilled Nursing Facilities,” *Skilled Nursing News* (May 24, 2021), <https://skillednursingnews.com/2021/05/buyers-have-voracious-appetite-for-skilled-nursing-facilities/>

<sup>5</sup> Maggie Flynn, “Nursing Home Prices per Bed Spike, Rising Almost 22% From 2020,” *Skilled Nursing News* (May 26, 2021), [https://skillednursingnews.com/2021/05/nursing-home-prices-per-bed-spike-rising-almost-22-from-2020-to-2021/?itm\\_source=parsely-api](https://skillednursingnews.com/2021/05/nursing-home-prices-per-bed-spike-rising-almost-22-from-2020-to-2021/?itm_source=parsely-api)

<sup>6</sup> See research cited in “Nursing Home Residents and COVID-19: Staffing and Quality of Care Matter” (CMA Alert, Dec. 3, 2020), <https://medicareadvocacy.org/nursing-home-residents-and-covid-19-staffing-and-quality-of-care-matter/>; “Nursing Facilities and COVID: Staffing Matters” (CMA Alert, Nov. 5, 2020), <https://medicareadvocacy.org/nursing-facilities-and-covid-staffing-matters/>; “Nursing Facilities and Covid-19 – it’s not Inevitable” (CMA Alert, Oct. 8, 2020), <https://medicareadvocacy.org/nursing-facilities-and-covid-19-its-not-inevitable/>; “Study Finds Lower Mortality Rates in Unionized New York State Nursing Facilities” (CMA Alert, Sep. 17, 2020), <https://medicareadvocacy.org/study-finds-lower-mortality-rates-in-unionized-new-york-state-nursing-facilities/>; “Nursing Facilities Owned by Private Equity Firms Have Higher Rates of Covid Infections than Other Facilities” (CMA Alert, Aug. 13, 2020), <https://medicareadvocacy.org/nursing-facilities-owned-by-private-equity-firms-have-higher-rates-of-covid-infections-than-other-facilities/>; “Studies Find Higher Nurse Staffing Levels in Nursing Facilities Are Correlated With Better Containment Of Covid-19” (CMA Alert, Aug. 13, 2020), <https://medicareadvocacy.org/studies-find-higher-nurse-staffing-levels-in-nursing-facilities-are-correlated-with-better-containment-of-covid-19/>; “COVID Does Not Have to Lead to Deaths in Nursing Homes” (CMA Alert, Jul. 23, 2020), <https://medicareadvocacy.org/covid-does-not-have-to-lead-to-deaths-in-nursing-homes/>

<sup>7</sup> New York State Attorney General Letitia James, *Nursing Home Response to COVID-19 Pandemic* (rev. Jan. 30, 2021), <https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf>

In addition, facilities have, for too long, ignored infection prevention and control deficiencies. The GAO reported in May 2020 that more than 82% of all nursing facilities nationwide were cited with infection control deficiencies between 2013 and 2017, with 40% of facilities cited each year.<sup>8</sup> With 99% of the deficiencies classified as no-harm – resulting in the complete absence of any financial penalty – facilities ignored the deficiencies and continued their poor practices. Infection control practices for COVID-19 are identical to long-standing infection control practices – staff must wash their hands, properly disinfect medical equipment that they use with multiple residents, identify and isolate residents who appear to have an infectious disease, among other well-known, well-established practices.

As Professor Kingsley persuasively writes, the SARS outbreak in 2003 was clear warning of what happens in a pandemic. Officials in Hong Kong learned from the SARS pandemic and took steps to prevent a recurrence; Hong Kong lost 30 residents to COVID-19 out of 76,673 patients in its 760 facilities.<sup>9</sup> Professor Kingsley writes that U.S. nursing facilities were not prepared for the pandemic and that “If there is no accountability, the next natural disaster in the form of a virus will result in mass fatalities of institutionalized skilled nursing patients.”

CMS should be taking steps to ensure that regulatory standards and their enforcement are adequate to prevent another devastating loss of life in nursing facilities. The Nursing Home Reform Law set out this duty clearly and explicitly in 1987: “It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this subchapter, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.”<sup>10</sup> CMS should be focused on taking steps to ensure that residents receive the care they need and are promised under the Reform Law and that nursing homes properly spend and account for the billions of dollars in public funding that they receive for providing care.

## Summary of Comments

**1. CMS must address the decline in therapy received by residents following implementation of the new reimbursement system.**

**2. CMS needs to recalibrate SNF rates immediately, with Fiscal Year 2022.**

**3. For the Quality Reporting System, CMS should broaden the proposed measure for health care associated infections to recognize and measure poor resident outcomes in addition to hospitalization. CMS should also expand the proposed measure for COVID-19 vaccinations to include all staff that have direct contact with residents (not just health care staff).**

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<sup>8</sup> GAO, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic*, GAO-20-576R (May 20, 2020), <https://www.gao.gov/assets/710/707069.pdf>

<sup>9</sup> David Kingsley, “The U.S. Nursing Home System Incurred Massive Fatalities Due to System Failure. Will We Forget it Happened?” (Blog, *Tallgrass Economics Finance & Politics*, posted May 28, 2021), <http://tallgrasseconomics.org/2021/05/the-u-s-nursing-home-system-incurred-massive-fatalities-due-to-system-failure-will-we-forget-it-happened/>

<sup>10</sup> 42 U.S.C. §1395i-3(f)(1)

**4. For the Value-Based Purchasing measure, CMS should not add any measures based on facilities' self-reported assessment data or the two patient-reported (also known as resident satisfaction) measures.**

**Detailed Comments**

Our detailed comments and recommendations for each area follow.

**1. CMS must address the decline in therapy received by residents following implementation of the new reimbursement system. Multiple changes are needed, as discussed below.**

CMS reports the dramatic 30% decline in therapy received by residents at SNFs, from 91 minutes per resident per day to 62 minutes per resident per day, and the substantial shift from individual therapy to group and concurrent therapy. 71 Fed. Reg. 19954, 19989. Independent researchers also confirm both immediate and gradual declines in physical and occupational therapy following the implementation of the patient driven payment model (PDPM) on October 1, 2019.<sup>11</sup> These two types of therapy are subject to the variable per day adjustment schedule, which automatically reduces the daily reimbursement rate by a fixed percentage to reflect the resident's continued stay in the facility under Part A. Speech language pathology, the third type of therapy, is not subject to the variable per day adjustment; provision of that therapy increased beyond CMS's expectations and predictions.<sup>12</sup>

Both the decline in the provision of therapy services and the shift from individual to group and concurrent therapy were predictable and predicted.<sup>13</sup> CMS needs to take swift action to ensure that residents receive the therapy they need to improve their functioning and, as confirmed and mandated by *Jimmo v. Sebelius*,<sup>14</sup> to maintain their function and to prevent or slow their decline or deterioration.

In the final rules creating PDPM, CMS wrote that if a facility provided more than 25% of a therapy discipline, CMS would provide the facility with a "non-fatal warning edit," a "reminder" that it is out of compliance – that is, there would be no actual consequence whatsoever to facilities for shifting from individual to group or concurrent therapy.<sup>15</sup>

To monitor facilities' conduct, CMS indicated that it would add new items to the PPS Discharge Assessment to identify minutes for each therapy discipline and the mode of therapy (that is, whether the therapy is individual, group, or concurrent), in recognition of concerns by commenters on the proposed rules and CMS itself that PDPM could lead to a considerable decline in therapy services.<sup>16</sup> The new items enabled CMS to monitor the total number of

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<sup>11</sup> Rachel A. Prusynski, Natalie E. Leland, Bianca K. Frogner, Christine Leibbrand, Tracy M. Mrroz, "Therapy Staffing in Skilled Nursing Facilities Declined After Implementation of the Patient Driven Payment Model," *JAMDA* (2021 – in press)

<sup>12</sup> 81 Fed. Reg. 19954, 19987, Table 23

<sup>13</sup> "Final rules for New Medicare Reimbursement System for Skilled Nursing Facilities: Goodbye, Therapy" (CMA Alert, Aug. 23, 2018), <https://medicareadvocacy.org/final-rules-for-new-medicare-reimbursement-system-for-skilled-nursing-facilities-goodbye-therapy/>

<sup>14</sup> No. 5:11-CV-17-CR (D.Vt. Jan. 2013)

<sup>15</sup> 83 Fed. Reg. 39162, 39239 Aug. 8, 2018)

<sup>16</sup> 83 Fed. Reg. 39162, 39235-39236 (Aug. 8, 2018)

minutes a resident receives therapy as well as the type of therapy.<sup>17</sup>

Despite expressing concerns about the dramatic changes in therapy following implementation of PDPM, CMS claims that residents did not experience significant change in health care outcomes, citing the absence of change in three measures: falls with major injuries, stage 2-4 pressure ulcers, and hospital readmissions. *Id.* 19986. The first two measures are based on self-reported minimum data set (MDS) information; self-reported MDS-based measures are notoriously inaccurate and understate poor resident outcomes.<sup>18</sup> Moreover, researchers have found that the specific measures relied on by CMS are inaccurate, understate poor outcomes, and are particularly inaccurate for nonwhite residents.

In the first “national-level assessment of how nursing homes self-report major injury fall rates, which are used by CMS for quality measurement and public reporting,” researchers “found substantial underreporting on the specific Minimum Data Set (MDS) item (J1900C) used by NHC [*Nursing Home Compare*].”<sup>19</sup> Only 57.5% of residents’ major injury falls that were identified in Medicare hospital admissions claims data were reported on residents’ assessment data.

Researchers analyzed 100% of major injury falls in hospital admissions claims data from the Medicare Provider Analysis and Review (MedPAR) for the period January 1, 2011 to September 30, 2015 (150,828 falls). They compared these claims data to facilities’ self-reported MDS data for the same period, focusing on J1900C (major injury during current stay), “as the responses to this question for long-stay residents are used to create an NHC quality measure and are part of the star rating algorithm.”<sup>20</sup> Researchers found

- Only 57.5% of the claims were reported on MDS.
- 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%).

Researchers also found poor correlations between claims-based falls rates and quality measure star ratings and overall ratings. At least 75% of the nursing facilities had a four- or five-star quality measure rating and half the facilities had four- and five-star overall ratings.<sup>21</sup> *Id.* 4-5, Table 4.

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<sup>17</sup> 83 Fed. Reg. 39162, 39237 (Aug. 8, 2018)

<sup>18</sup> Katie Thomas, “Medicare Star Ratings Allow Nursing Homes to Game the System,” *The New York Times* (Aug. 24, 2014), <https://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html?searchResultPosition=4>; Abt Associates, *Nursing Home Compare Five-Star Quality Rating System: Year Five Report [Public Version] Final Report*, p. 32, Figure 3.9 (Jun. 16, 2014) (documenting the dramatic shift in the distribution of quality measure ratings, 2009-2013)

<sup>19</sup> Prachi Sanghav, Shengyuan Pan, Daryl Caudry, “Assessment of nursing home reporting of major injury falls for quality measurement on nursing home compare,” *Health Services Research*, p. 5. 2019;00:1-10. <https://doi.org/10.1111/1475-6773.13247>

<sup>20</sup> *Id.* 2

<sup>21</sup> *Id.* 4-5, Table 4

As a matter of policy, the researchers suggest that “claims-based measures may be useful supplements or replacements for the MDS-based patient safety indicator.”<sup>22</sup>

A recent study similarly found that SNFs substantially under-report both falls and pressure ulcers. Comparing pressure ulcer rates reported by SNFs with pressure ulcer rates from patients who were readmitted to the hospital from the SNFs, Integra Med Analytics find that SNFs under-reported three quality measures – pressure ulcers, urinary tract infections (UTIs), and falls.<sup>23</sup> The researchers find “low correlations between self-reported and hospital-based measures for pressure ulcers, UTIs and falls at .02, .04 and .09 respectively, indicating that the self-reported measures were inconsistent with hospital-based diagnoses.”

Integra Med Analytics reports, “The median ratio of the self-reported and hospital-based pressure ulcer rates was 0.48, indicating that over half of SNFs under-reported by at least a factor of two.” The researchers describe their analysis as “a conservative measure of under-reporting; the hospital data only included patients that were re-admitted to the hospital in the numerator and any SNF patients with pressure ulcers that were not re-admitted to the hospital weren’t counted.”

The consequences of under-reporting were significant. One facility studied by the company “had a low self-reported UTI rate of less than 1 in 1,000 which is in the first percentile of the self-reported rates. However, 5.8% of this SNF’s admissions were re-hospitalized with a UTI, which is in the 86<sup>th</sup> percentile for the hospital-based measure.”

In addition, the limited measures considered by CMS do not reflect the full range of poor outcomes that residents can experience from the lack of necessary therapy. Residents denied therapy or receiving limited non-individualized therapy may lose the ability to walk, transfer, or feed themselves and may experience psychological decline and psychosocial harm as a result of losing or failing to regain or retain the ability to complete activities of daily living as independently as possible.

### **Recommendations about therapy under PDPM**

- 1. CMS should analyze the resident Discharge Assessment data since implementation of PDPM and should publicly report its findings.**
- 2. CMS should add a mandatory financial penalty for facilities that exceed the 25% cap on group or concurrent therapy, with the penalty set at an amount to exceed the cost of compliance with the limitations on group or concurrent therapy.**
- 3. CMS should identify nursing facilities that dramatically changed the therapy services they provide following implementation of PDPM and direct state survey agencies to conduct surveys at those facilities in order to identify whether they violated the Requirements for Participation, including resident assessment and care planning, professional standards of quality, and provision of care and services. If survey agencies identify noncompliance, CMS should cite appropriate deficiencies and impose enforcement actions, specifically, per day civil money penalties that**

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<sup>22</sup> *Id.* 6, 8

<sup>23</sup> Integra Med Analytics, *Underreporting in Nursing Home Quality Measures* (Aug. 2020), <https://www.nursinghomereporting.com/post/underreporting-in-nursing-home-quality-measures>

**exceed the cost of compliance.**

- 4. CMS should consider reinstating a requirement for multiple resident assessments (as in the prior reimbursement system, Resource Utilization Groups) to prevent the gaming (and overstatement) that occurs with the single assessment on the fifth day of a resident's stay, as now required by PDPM.**

## **2. CMS needs to recalibrate SNF rates immediately, with Fiscal Year 2022.**

CMS is considering recalibrating SNF reimbursement rates in light of the “scope and magnitude” of the dramatic rate increases that followed implementation of PDPM – a 5.3% increase (more than \$1.7 billion) – not the budget neutrality that CMS intended. *Id.* 19987. The Center and Consumer Voice oppose both delayed implementation and a phased-in implementation of recalibration of rates. The only reason identified by CMS for not immediately recalibrating rates is concern for the “burden” on SNFs. This concern is not persuasive.

The behavior by SNFs in shifting therapy practices to maximize reimbursement was deliberate and calculating as well as harmful to residents in ways that CMS is neither considering nor measuring (as discussed above).

Moreover, such concerns for SNF finances did not affect CMS's prior recalibrations of SNF reimbursement rates a decade ago. CMS reports that the transition to RUG-IV in Fiscal Year 2011 led to considerable overpayments to SNFs. *Id.* 19985. CMS immediately recalibrated the rates prospectively for FY 2012, reducing rates by 12.5% (\$4.47 billion).<sup>24</sup> *Id.* The rate recalibration that is needed now, following the implementation of PDPM, is just over one-third the rate and dollar amount of the RUG-IV overpayments. As in 2011, CMS should immediately recalibrate the rates. CMS should prevent continuation of the \$1.7 billion overpayment to SNFs that followed implementation of PDPM, reflecting just 5.0% of the 5.3% overpayment.

## **Quality Reporting Program**

### **Health care associated infections**

CMS persuasively presents the importance of a new measure for health care associated infections (HAIs). *Id.* 19991-19993. Facilities have higher rates of HAIs when they have high staff turnover, low staff-to-resident ratios, and high occupancy rates and when they are operated on a for-profit basis. *Id.* 19992. Inadequate prevention and treatment of HAIs results in poor health care outcomes for residents and higher health care costs, including “longer lengths of stay, use of higher-intensity care”). *Id.* Among other evidence, CMS cites the HHS Inspector General's 2014 report that one in four adverse events among residents during a Medicare-covered SNF stay averaging 15.5 days was due to an HAI and that more than half of the adverse events were potentially preventable.<sup>25</sup>

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<sup>24</sup> See proposed rule at 76 Fed. Reg. 26363, 26370-26377 (May 8(6, 2911), and the final rule, 76 Fed. Reg. 48485, 48492-48500 (Aug. 8, 2011)

<sup>25</sup> *Adverse Events in Skilled Nursing Facilities: National Incidence among Medicare Beneficiaries*, OEI-06-11-00370 (Feb. 2014), <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>

However, CMS proposes to limit the measure to HAIs requiring inpatient hospitalization, even though it acknowledges that not all HAIs require hospitalization.

The Center and Consumer Voice appreciate and fully support CMS's interest in using claims-based measures, such as inpatient hospitalization, rather than self-reported and inflated MDS-based measures. Nevertheless, this limitation on use of the HAI measure will undercount HAIs leading to negative outcomes for residents that did not lead to inpatient hospitalization (or that led to emergency room or observation status visits, which are not counted as inpatient hospitalizations).

CMS also proposes to use risk adjustments for this measure based on "age and gender characteristics, original reason for Medicare Entitlement, principal diagnosis during the prior proximal inpatient (IP) stay, types of surgery or procedure from the prior proximal IP stay, length of stay and ICU/CCU utilization from this prior proximal stay." *Id.* 19994. Risk adjustments for outcomes-based measures inherently mask bad outcomes for residents, including outcomes that result directly from poor provider performance.

Federal law requires facilities to conduct comprehensive assessments of residents and to develop care plans to meet residents' assessed needs. **Excusing bad outcomes because a resident is at special or higher risk essentially excuses facilities from not properly assessing a resident and appropriately providing the care that the facility determines is needed.**

In an early public meeting on measures, it was proposed that the resident weight loss measure be risk-adjusted for residents who needed to be fed. An outraged nursing owner said at the meeting that risk adjustments should not be made for behaviors that are under the control of facilities in meeting or not meeting residents' needs. He had residents in his facility who needed to be fed, he said, but they did not lose weight because staff at his facility fed them.

### **COVID-19 vaccination measure**

CMS proposes to add a COVID-19 vaccination measure in light of the devastating impact of COVID-19 on nursing home residents and staff. *Id.* 19994-19999. The Center and Consumer Voice support a COVID-19 vaccination measure and its public reporting on the *Care Compare* website, but oppose its limitation to health care personnel (a term that is not defined in the proposed rule).

Many non-health care personnel have frequent direct contact with residents. Dietary and housekeeping staff, feeding assistants, as well as social services and activities workers also have frequent direct contact with residents and should be included in the measure. Their vaccination rates matter.

### **Recommendations about Quality Reporting System**

- 1. CMS should not limit the HAI measure to residents who are hospitalized as a result of an infection, but should identify, and include in the measure, additional indications of negative outcomes from HAIs.**
- 2. CMS should not risk adjust the HAI measure. Risk adjustment excuses and masks poor resident outcomes.**

- 3. CMS should include all staff at nursing facilities who come in direct contact with residents in the COVID-19 vaccination measure. The measure should not be limited to health care personnel.**

### **Value-Based Purchasing Program**

The Center and Consumer Voice support the expansion of measures under the Value-Based Purchasing Program beyond the 30-day all cause rehospitalization measure.

CMS's repeated expressions of concern with not penalizing facilities for issues "distorted by COVID-19" is overstated and inappropriate. As discussed above, the pandemic would not have been as devastating for residents and workers if facilities had treated infection prevention and control deficiencies more seriously over the years and if they had staffed facilities with sufficient numbers of well-qualified staff. As MedPAC repeatedly documents, SNFs have had more than sufficient reimbursement to meet these standards.

The Center and Consumer Voice oppose any new measures based on self-reported MDS data. As discussed above,<sup>26</sup> these measures are inaccurate and inflated and make facilities look better than they actually are.

The Center and Consumer Voice also strongly oppose the two patient-reported measures. Historically, facilities have used "customer satisfaction" surveys as part of their marketing activities. Moreover, the survey process already includes surveyor discussions with residents and the resident council or its representatives. If CMS believes that more information from residents would be useful and should be reported, and the Center and Consumer Voice agree that residents' voices are essential, CMS should expand upon and strengthen this part of the federal survey protocol.

The CoreQ: Short Stay Discharge measure<sup>27</sup> uses four questions that are vague and virtually meaningless (e.g., Overall, how would you rate the staff. How would you rate how well your discharge needs were met). Residents who are asked about staff often express concern for their limited numbers and say that staff do the best they can, under the circumstances. Giving a positive rating does not mean residents believe staffing is actually adequate to meet their needs. Similarly, if residents do not know what tasks a facility is required to perform on discharge, they cannot meaningfully evaluate whether the services they received were effective and appropriate. Questions about discharge provide limited, if any, information about how the facility provides care to resident on an ongoing basis.

The denominator exclusions include several inappropriate exclusions. Why are residents discharged on hospice excluded? Why exclude residents who left the SNF against medical advice? They may have left because they found the SNF intolerable.

### **Recommendations about Value-Based Purchasing Program**

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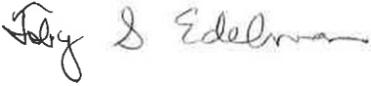
<sup>26</sup> See notes 19-23, *supra*

<sup>27</sup> CoreQ: Short Stay Discharge Measure, [https://cmit.cms.gov/CMIT\\_public/ViewMeasure?MeasureId=3436](https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=3436)

- 1. CMS should not base any new measures on facilities' self-reported MDS data.**
- 2. CMS should not add the patient-reported measures.**

Thank you for the opportunity to submit comments.

Sincerely,

A handwritten signature in black ink that reads "Toby S. Edelman". The signature is written in a cursive style with a large initial "T" and a long horizontal stroke at the end.

Toby S. Edelman  
Senior Policy Attorney  
Washington, DC