June 3, 2022

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

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels [CMS–1765–P] RIN 0938–AU76

Dear Administrator Brooks-LaSure:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,500 long term and post-acute care facilities, or 1.07 million skilled nursing facility (SNF) beds and more than 5,000 assisted living centers. We represent the majority of SNFs across the country and a rapidly growing number of assisted living communities. 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 2023; Request for Information on Revising the Requirements for Long-Term Care Facilities To Establish Mandatory Minimum Staffing Levels***, ***FY23 Notice of Proposed Rulemaking***" (SNF Proposed Rule). This document is our final and complete comment letter building upon our preliminary comment letter submitted on May 12, 2022.

Before providing an overview of our SNF Proposed Rule comments, we would like to thank you and the CMS team for the focus of the Patient-Driven Payment Model's (PDPM) on patients. Without PDPM's focus on patient characteristics and related shift away from service-based metrics, specifically therapy minutes, we believe delivering care in the COVID-19 crisis would have been almost impossible. Also, we greatly appreciate the opportunity to comment again upon a possible parity adjustment, isolation coding, and the minimum staffing RFI.

Additionally, we greatly appreciate extensions of the Public Health Emergency (PHE) which have provided important flexibilities to SNFs during the COVID-19 pandemic. In particular, the

telehealth waivers have aided with our significant workforce challenges and the Section 1812(f) as well as Section 1135 waivers also have aided with creating efficiencies and providing Medicare beneficiaries with helpful treatment options. Finally, CMS' commitment to notification of a PHE phase-down is key and we urge the Agency to work with providers and states to develop mutually agreeable glide paths to normal operations. This is particularly critical as the SNF sector continues to struggle to recover from pandemic impacts.

SNF Sector Context and Priority Comment Areas and Context

Our comment letter opens with a overview of the current state of the sector. Lingering challenges from the pandemic, crippling workforce challenges, and inflation impacts are important to under in terms of our comments. Below, we list our key comment areas in order of the NPRM. Our high priority comment areas are in **bold** font.

NPRM Comment Area	AHCA Comment in Brief
Market Basket	AHCA proposes adjustments to the market basket labor weights and price proxies are needed to better keep pace with rapidly escalating labor costs
Wage Index Decrease Cap	AHCA supports this proposal. Providing a cap offers some predictability with year-over-year wage index updates
Parity Adjustment	AHCA provides analysis supporting additional refinements to the parity adjustment analysis approach, supports the proposed distribution of the final adjustment amount across components evenly, and proposes a three-year phase-in of the parity adjustment due to the ongoing challenges with labor costs and impacts of COVID
Infection Isolation	AHCA offers a rationale, data, and proposed solution approaches for CMS to advance changes to the MDS and PDPM Nursing and NTA components to account for costs of cohorted isolation when following public health guidance
SNF QRP	AHCA opposes adoption of HCP influenza vaccination measure until numerous provider protection concerns are addressed, we support the revised compliance date for certain QRP TOH and cross-setting items beginning FY 2024, and we submitted comments related to the three RFIs, including support for the adoption of CoreQ short stay measure
SNF VBP	AHCA concerns that several of the proposed measures and scoring methodology may exacerbate racial and ethnic disparities.
Minimum Staffing RFI	AHCA recommends that CMS conduct a study true to minimum levels, considering type of facility (one size does not fit all).

While all of our comment areas are important to the SNF profession, we highlight market basket, parity adjustment and minimum staffing due to the daunting workforce challenges we face which jeopardize access to care. Our comment letter offers a longer than typical discussion of the SNF sector to better put into perspective our comments. We then provide comments on the areas noted above with extensive commentary and data analytics on Market Basket, Parity Adjustment and the Minimum Staffing RFI.

Finally, we recognize our comment letter is extensive. A significant portion of our comments are conveyed in charts, graphs, and other images creating a lengthy document. Our goal is provide CMS with as much information as possible which validates the SNF sector crisis. Due to the gravity of the challenges faced by the sector, we felt in depth discussions are merited. We appreciate CMS' valuable time spent reviewing our comment letter.

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

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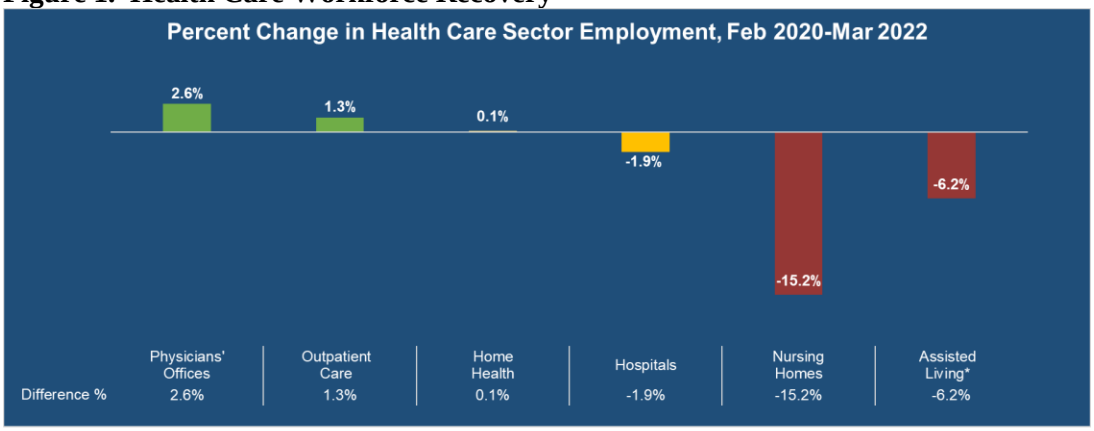
I. SNF Sector Context – Quality and Access Risks

As well documented, SNFs are disproportionately impacted by the workforce crisis, as well as inflation, and time is needed to adapt to what we believe is a long-term workforce challenge. As our population ages, we want to move past temporary holds on admissions as well as temporary and permanent closures. We would like to work with CMS on constructive, workable solutions. Below, we offer empirical evidence of the workforce crisis and it impacts on quality of and access to care to support our key comments. We believe this evidence supports our comments on market basket, parity adjustment and the minimum staffing RFI.

- ***SNFs Are Disproportionately Impacted by the Health Care Workforce Crisis.*** While other health care sectors have recovered or are beginning to recover, SNFs continue to struggle (see ***Figure 1***, below). Stigma, healthcare workforce competition, and a lack of resources to offer competitive wages for skilled health care workers in all positions are key barriers to recovery.

Figure 1. Health Care Workforce Recovery



Source: Bureau of Labor Statistics (BLS) February 2020 – March 2022
*Assisted Living BLS data through February 2021

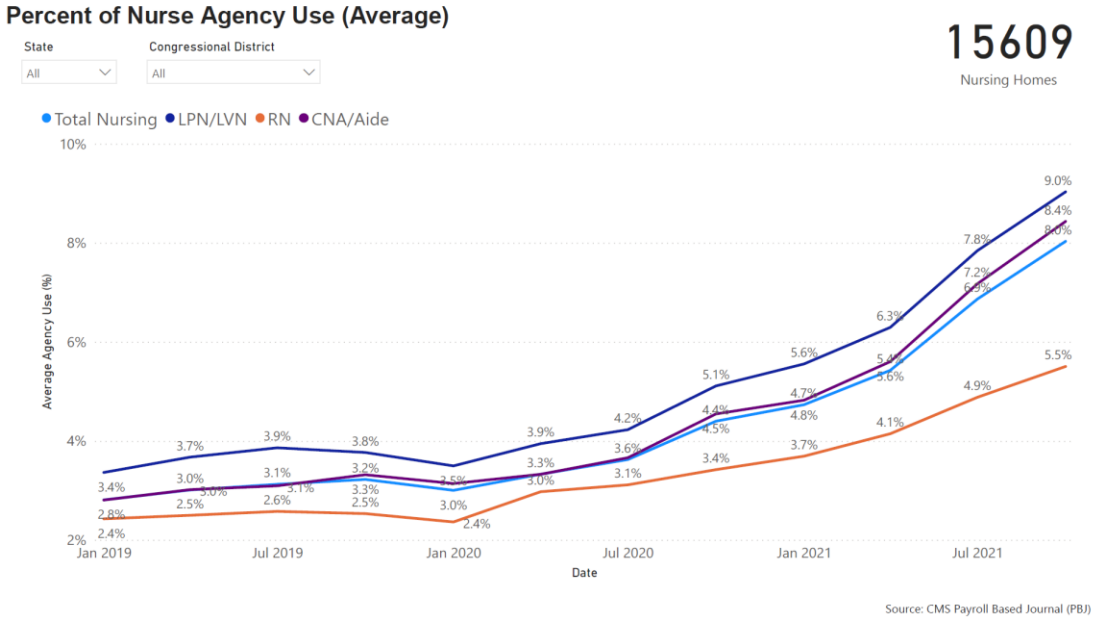
Recently released research by the Department of Health and Human Services, Assistant Secretary for Research and Evaluation (ASPE) also found that SNFs are disproportionately impacted by the health care worker shortage stating, "… there was significant variation by sector. This overall number includes an increase of 241,800 employees in ambulatory health care services, as well as a decline of 32,900 employees in hospital employment and a decline of 145,600 employees in nursing and residential care facilities."[1] Efforts to retain the existing workforce has resulted in double digit increases in labor costs heavily driven by the need to use contract agencies to fill critical positions particularly Certified Nursing Assistants (CNAs), Licensed Nurse Practitioners (LPNs) and Registered Nurses (RNs). A sample of 752 buildings reported an average of 18% increase in labor costs 2020 actual compared to 2021 actual.

[1] HHS Assistance Secretary for Planning and Evaluation, "***Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce***." May 3, 2022.

- ***Impacts of Contract Labor.*** To ensure quality and meet direct care needs, the SNF sector has been pushed to increasingly turn to contract labor (see ***Figure 2***, below). These are temporary staffing agencies which supply hospitals and SNFs with direct care staff typically RNs, LPNs, and CNAs. Use of contract labor has two significant implications. First, use of staff rotating in and out of buildings and, therefore, inconsistent staffing within a building, negatively impacts quality of care.[2] Use of contract labor also can lead to variability in staffing levels which also impacts quality of care.[3] Second, use of contract labor further exacerbates the financial crisis based by the SNF sector as their costs are substantially greater.

  An analysis of contract labor costs from a sample of 752 geographically dispersed SNFs found an average increase of $350,000 per building 2021 actual to 2022 projected. One large not-for-profit provider notes that, "For 2021, our YTD actual staffing agency expense was $62,148,116 compared to a budget of $17,812,690." Furthermore, an independent study by Clifton Larson Allen found that contract labor costs have doubled (see ***Figure 3***, below).[4] Such increases are untenable in terms of both delivering quality care as well as the financial stability of the SNF sector.

Figure 2. Increasing Reliance on Contract Labor



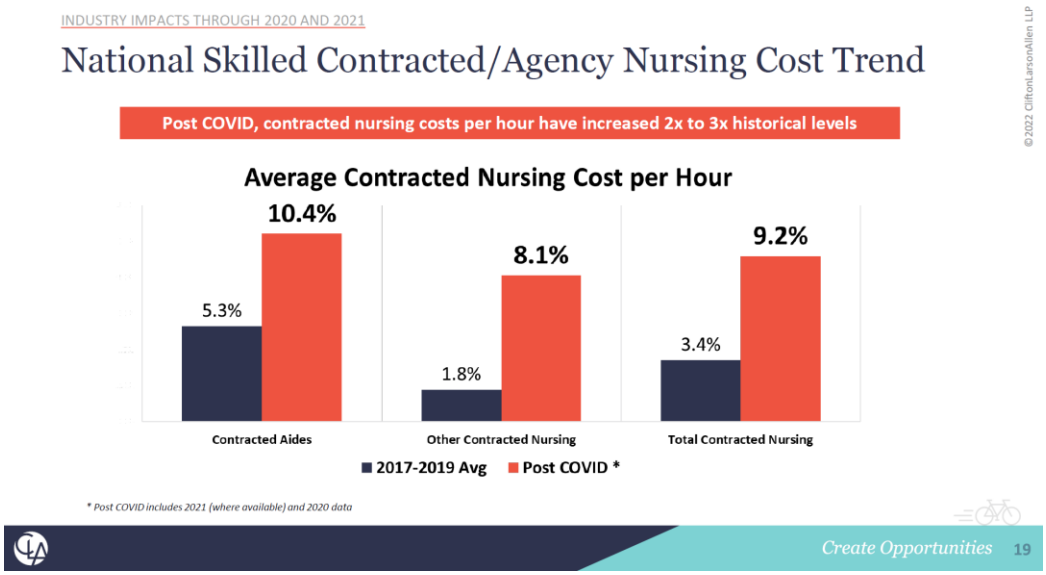
Note: Data represents percent increase in use of contract labor

[2] Rahman A, Straker JK, Manning L. ***Staff assignment practices in nursing homes: Review of the literature,*** Journal of the American Medical Directors Association, 2009, vol. 10 (pg. 4-10)

[3] Dana B. Mukamel, PhD; Debra Saliba, MD, MPH; Heather Ladd, MS; R. Tamara Konetzka, PhD. ***Daily Variation in Nursing Home Staffing and Its Association With Quality Measures***. JAMA Network.

[4] Clifton Larson Allen. ***State of the Nursing Facility (SNF) Industry.*** February 2022.

Figure 3. Increasing Contract Labor Costs.

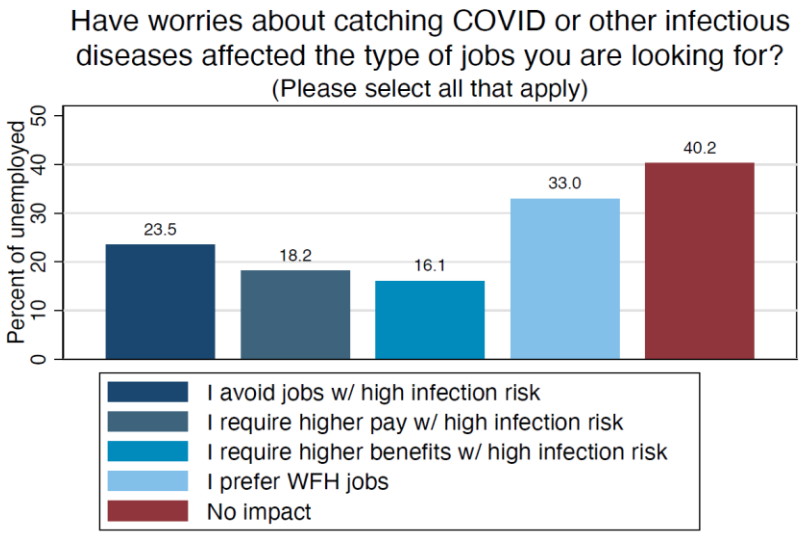


Other independent research, conducted by IBISWorld, found that health care contract agency revenue is projected to total $25 billion in 2022. This is driven by 4.4% year over year growth 2017 – 2021 and 6.4% growth to-date in 2022, alone.[5]

- ***Workforce Challenges Likely to Continue.*** Preliminary research indicates SNFs are likely to continue to experience workforce shortages. New research suggests, millions have no intention of ending some pandemic behaviors even if the threat from the coronavirus and its variants were to fully subside. This includes not returning to their previous jobs. Roughly 13 percent of people in the most recent study reported that they did not intend to change their protective behaviors. The demographics of this population align with the demographics of a large portion of the traditional SNF workforce – primarily women of color who also are of low income. ***Figure 4***, below, illustrates why SNFs are likely to continue to struggle with workforce recovery – primarily driven by the continued perception that work in a SNF is high risk for COVID infection despite significant infection control and prevention efforts.

[5] **Healthcare Staff Recruitment Agencies in the US** - Market Size 2005–2026. IBISWorld.

Figure 4. Preliminary Research Shows Bias Against Perceived High-Risk Jobs[6]



Note: WFH indicates "Work from Home"

In other research, the population noted most unlikely to return to their previous jobs are primarily women who are low income and have low levels of health literacy. This group comprises the preponderance of SNF direct care staff. The ASPE study noted above arrived at similar findings and discusses preliminary findings on long COVID which also likely is impacting return to work.[7] The ASPE study also notes significant drops in enrollment in RN and LPN programs which likely will take years to address.

Finally, in terms of non-clinical workers, SNFs also will be in an increasingly competitive labor market. The data shown below provides an overview of future further tightening of the working-age population without a bachelor's degree. It is from this workforce population that SNFs draw the vast majority of its non-clinical workforce (Laundry, Dietary, Housekeeping, Activities, CNAs, Medical Records, Office/Support, etc.).[8] Researchers also project labor shortages to continue in all sectors of the economy further escalating competition for labor while also subject to public payment limitations and provider responsibilities to provide around the clock care at appropriate and required staffing levels.[9, 10]

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[6] Barrero, Jose Maria, Nicholas Bloom, and Steven J. Davis, 2021. "***Why Working from Home will Stick***," National Bureau of Economic Research Working Paper 28731.

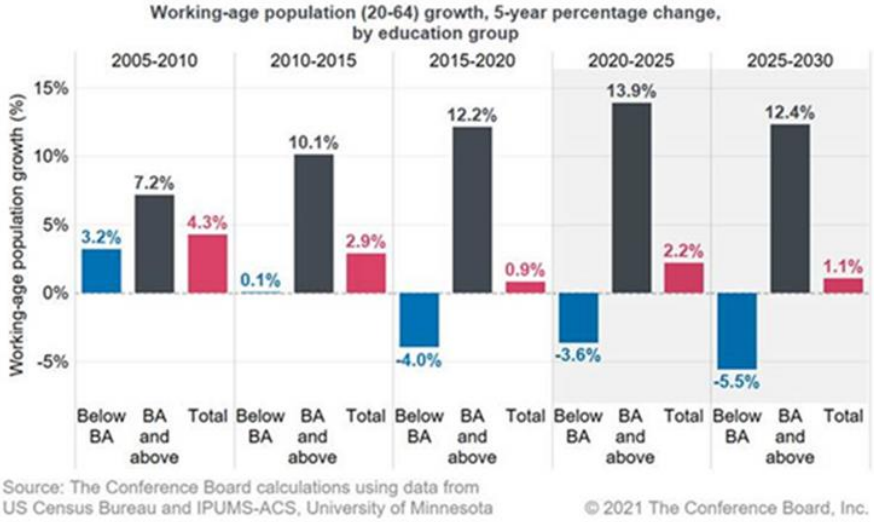
[7] HHS Assistance Secretary for Planning and Evaluation, "***Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce***." May 3, 2022.

[8] "***Why Wages Are Growing Rapidly Now— And Will Continue to in the Future.***" The Conference Board, August 2021. Available at: https://www.conference-board.org/publications/Why-Wages-Are-Growing-Rapidly

[9] Ibid.

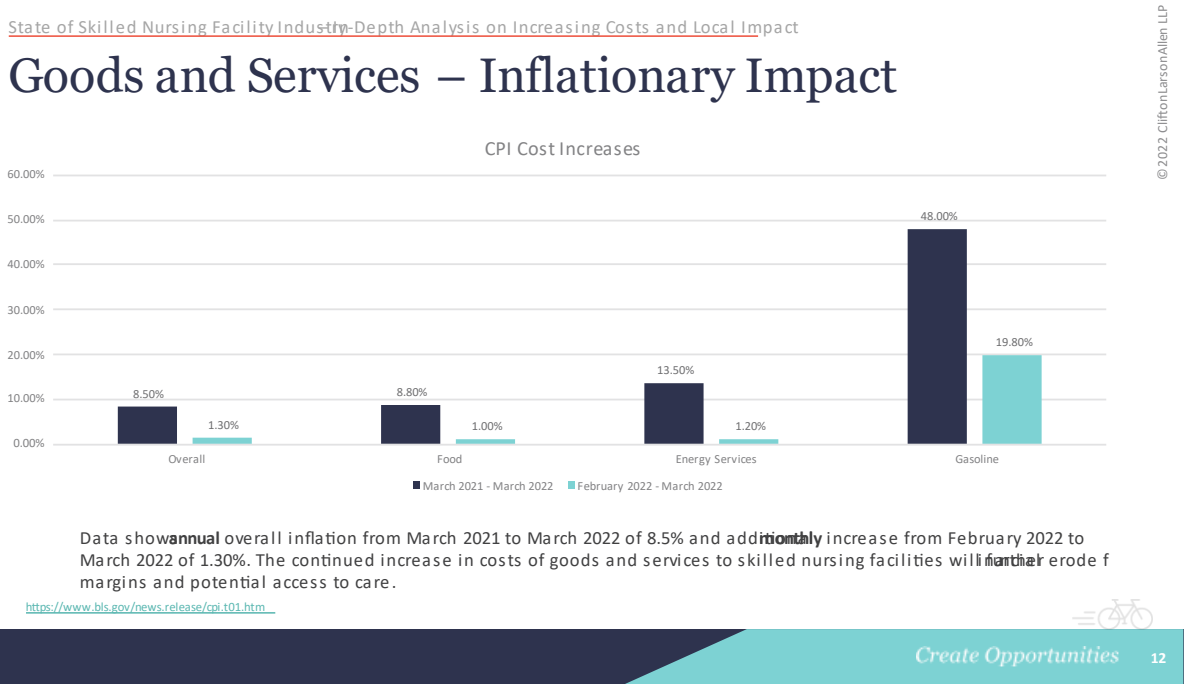
[10] ***"2022 salary increases will be the highest since 2008,"*** The Conference Board, December 2021. Available at: https://www.conference-board.org/research/economy-strategy-finance-charts/Salary-Budget-Increases-2021

Figure 5. Declining Number for Workers Below-BA Level



- ***Inflation Driving Up Non-Labor Operating Costs*.** In addition to labor costs, as with all sectors of the economy, SNFs also are struggling with non-labor inflation. In a second independent study, CLA noted significant increases March 2021 – March 2022 as well as more disturbing jumps in costs February 2022 – March 2022. CLA analysts indict that notable one-month jumps are indicative of increasing non-labor costs over the course of 2022 which will further exacerbate workforce costs issues. See ***Figure 5***, below.

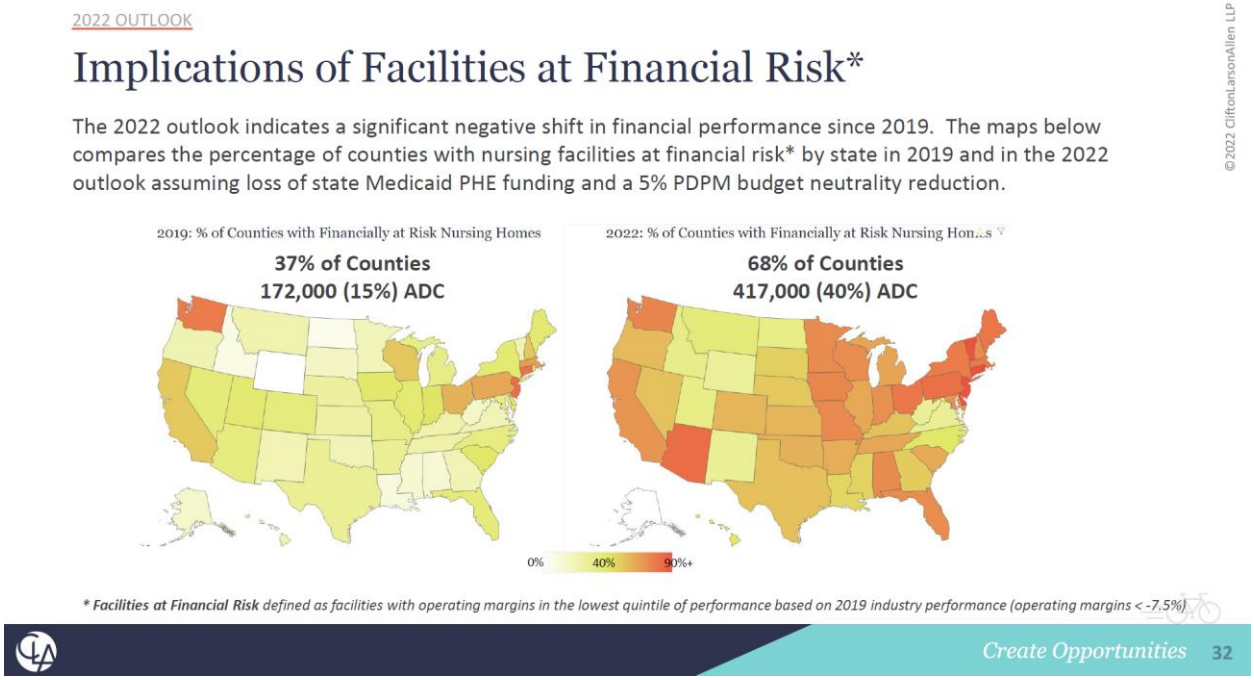
Figure 5. Non-Labor Inflation Increases



- ***Emerging Access Issues – Interaction of Workforce Challenges and Occupancy.*** SNF occupancy began declining during the pandemic, slightly recovered, but then plateaued largely due to the workforce crisis. AHCA members report freezing admissions, temporary closure of buildings and permanent closure of buildings due to occupancy challenges driven by the lack of direct care staff. An independent study conducted by Clifton Larson Allen (CLA) indicates that a substantial portion of buildings are at risk of closure resulting in significant numbers of displaced patients and residents.[11] See ***Figure 5***, below.

[11] Clifton Larson Allen. ***State of Skilled Nursing Facility (SNF) Industry.*** February 2022.

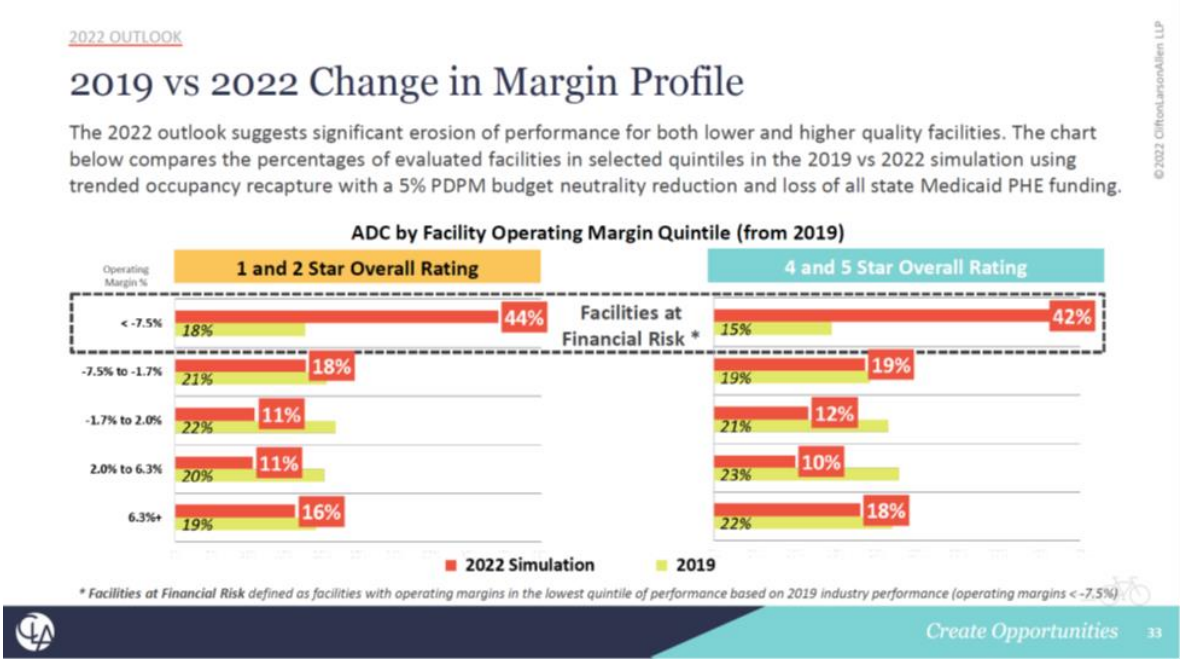
Figure 5. Buildings at Risk of Closure.



Using CLA's methodology, at risk is defined at buildings with a operating margin of < 7.5%. In 2019, 37% of counties in the US had buildings at risk. Access to care risk is framed as the Average Daily Census (ADC) of these buildings. The ADC at risk of access challenges in 2019 was 172,000 patients/residents. CLA projects that by year end 2022 if a full parity adjustment is implemented, the number of counties with at-risk buildings almost doubles to 68% and the number of patients/residents whose access is at-risk more than triples to 417,000. In the charts above, the darker shading indicates states with higher concentrations of at-risk buildings and people. Of particular concern to us is the identification on a state by state basis of the location of these SNFs at risk – mostly in rural and/or low-income communities where beneficiaries and their families are already experiencing challenges with access to care; and where hospitals are challenged with finding appropriate discharge locations within a reasonable geographic boundary.

CLA research also shows that high quality buildings (e.g., 4 and 5 Star buildings) also are at-risk of closure jeopardizing access to high quality SNFs**.** See ***Figure 6*** below.

Figure 6. Overview of High-Quality Buildings at Risk of Closure.



Using the same at-risk definition of a negative operating margin of <7.5%, CLA found that of the at-risk buildings in 2019, 15% of those buildings had a 4 or 5 star rating. If a parity adjustment is implemented, the number of at-risk buildings also with 4 or 5 Star Overall Rated buildings jumps to 42%.

- ***Health Care Affordability, Health Equity, and SNF Impacts***. In its National Health Care Expenditures Report, CMS forecasts total healthcare spending will increase 50.2% from 2022 to 2030, but household out-of-pocket spending will increase only 41.4%. This forecast suggests growing affordability issues for consumers. Such increases could force more low-income Americans on to Medicaid and/or make Medicare deductible and coinsurance costs difficult to cover with the latter potential resulting in increases in the number of parity and full dual eligible individuals. By definition partial and full duals are more often women of color, from low-income households, have multiple chronic conditions and lower levels of health literacy impacting their ability to actively participate in their plans of care. While the SNF sector is positioned to care for high-need populations significant and ongoing increases such as these coupled with jumps in fixed overhead costs present serious challenges associated with meeting patient and resident needs.

  In a second independent CLA report, entitled ***State of the Skilled Nursing Facility Industry, In Depth Analysis of Increasing Costs and Local Impact***, CLA examined in more detail the counties which contain at-risk facilities as well as the populations in those counties and facilities.[12] In brief, CLA found:

[12] **State of the Skilled Nursing Facility Industry, In Depth Analysis of Increasing Costs and Local Impact.** Clifton Larson Allen. May 2022. Available at: ***https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/AHCA%20-***

- *Racial and Ethnic Minority Groups More At-Risk of Displacement.* Counties with facilities at financial risk have a materially higher percentage of racial and ethnic minority population than those with lower percentages. Additionally, at-risk nursing facilities deliver care to higher percentages of ethnic and minority populations than those not at risk. This data suggests the potential for a disproportionate impact on racial and ethnic minority populations should facilities at financial risk reduce bed capacity due to staffing availability and costs, closure, or other environmental risks. Specifically, counties containing at-risk SNFs had on average approximately an 8% higher mix of racial and ethnic mintority groups. More alarming, at-risk SNFs had close to a 7% higher proportion of racial and ethnic minority groups than SNFs not at-risk.
- *Racial and Ethnic Inequities Extend to High-Quality Facilities*. High-quality SNFs in counties with facilities at financial risk have a higher percentage of racial and ethnic minority nursing home residents than counties with no facilities at financial risk. This data suggests the potential for a disproportionate impact on racial and ethnic minority populations should high quality facilities at financial risk reduce bed capacity due to staffing availability and costs, closure, or other environmental risks. Specially, counties with 4-Star Buildings have a 5.2% higher mix of racial and ethnic minority residents compared to those counties without at-risk facilities. While counties with 5-Star buildings have a 3.9 higher population of racial and ethnic minority residents compared to those counties without at-risk facilities.
- *Health Care Needs are Higher in At-Risk Facilities*. The average risk score or beneficiary risk score is a measure of the relative clinical complexity of residents. Nationally, counties with facilities at financial risk have a somewhat higher average risk score for nursing home residents than counties with no facilities at financial risk. As the risk score increases, the likelihood an individual resident will experience a negative outcome increase. While these statics are less striking than the ethnic and racial disparities, due to the workforce crisis serious questions are raised about how or where these residents would find alternative placement should their current nursing facilities close. AHCA has heard from providers in the mid-west and rural upper New England about serious issues with residential placement (both alternative SNFs as well as HCBS placement) following building closures.

We look forward to working with CMS on averting the potential for devasting outcomes associated with closures that put our nation's older adults, individuals who are medically fragile, and their families, at risk due to lack of services.

%20State%20of%20Skilled%20Nursing%20Facility%20Industry%20-%20In-Depth%20Analysis%20on%20Increasing%20Costs%20and%20Local%20Impact.pdf

Section II. Market Basket – Addressing Labor Costs

(Note: CMS Office of the Actuary Staff Would Benefit from Reviewing Section 1 of Our Comment Letter in Tandem with this Section)

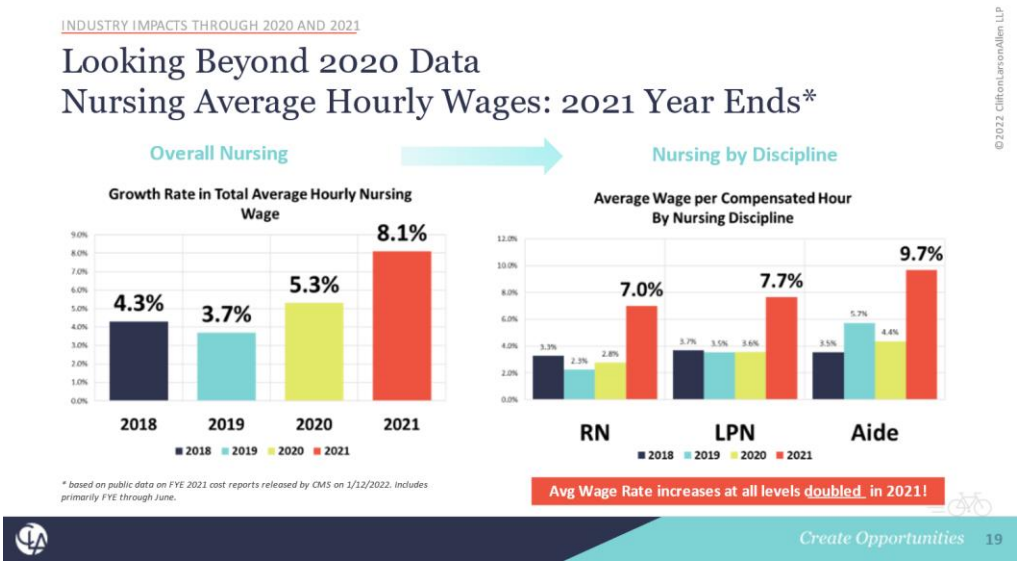
AHCA Comments: 1) To provide immediate assistance, AHCA desperately needs CMS to provide a labor-related market basket price add-on based due to serious workforce shortages and challenges with the current market basket methodology; 2) CMS should update the SNF Market Basket more frequently than every four to five years. and 3) AHCA respectfully requests that CMS work with the sector to develop a more accurate labor market basket price proxy methodology as well as a policy for triggering increases when similar workforce crises arise.

1. *Rationale*

AHCA believes the workforce challenges will continue for the reasons discussed extensively in Section I including permanent changes in labor costs (a) due to a shrinking blue collar and manual service sector workforce, (b) perception by potential workers of dangers and difficulty associated with jobs in the health care sector despite the availability of vaccines, PPE and infection control policies and practices and (c) low unemployment rate brought on by an overall shrinkage in the working age labor market. Economic theory dictates that true wage growth reacts to wage growth drivers such as tightness of a labor market and consumer inflation. Thus, indicators that are more correlated with these wage growth drivers probably measure true wage growth more accurately. For this reason, we believe attention to growth trajectories of payments for labor is critical.

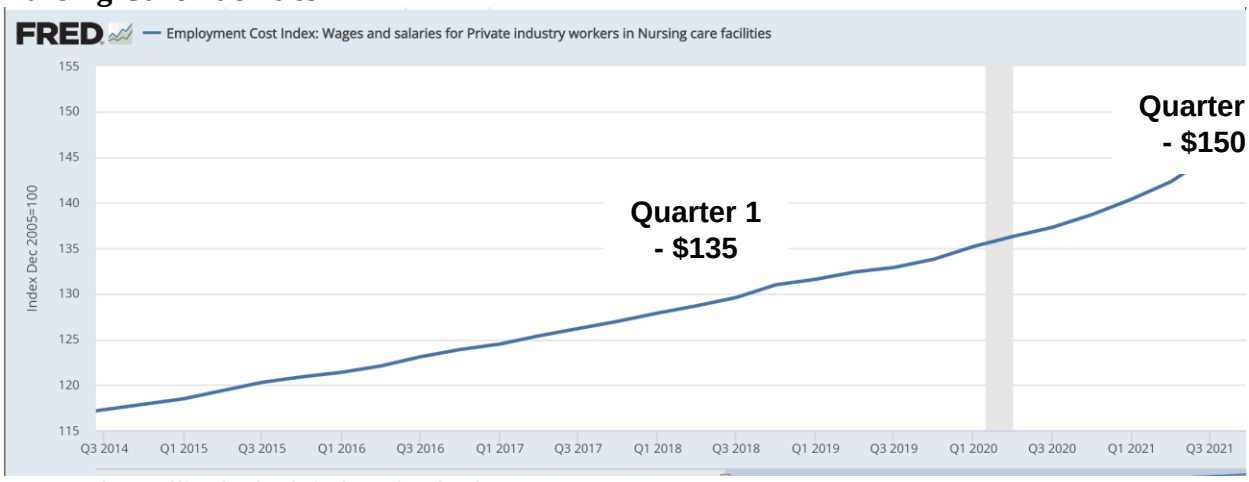
In terms of justifying such an urgent request, CLA found that direct average wage rate increases doubled in 2021. Labor experts believe these trends will continue for the foreseeable future as noted in Section 1.

Figure 1. CLA Analysis of Medicare Cost Report Data



Between Quarter 1 2018 and Quarter 1 2022, wages and salaries for all SNF employees increased by over 11% according to the Bureau of Labor Statistics (e.g., increasing from $135 in Quarter 1, 2018, to $150 in Quarter 2, 2022.

Figure 2. Bureau of Labor Statistics, Wages and Salaries for Private Industry Workers in Nursing Care Facilities

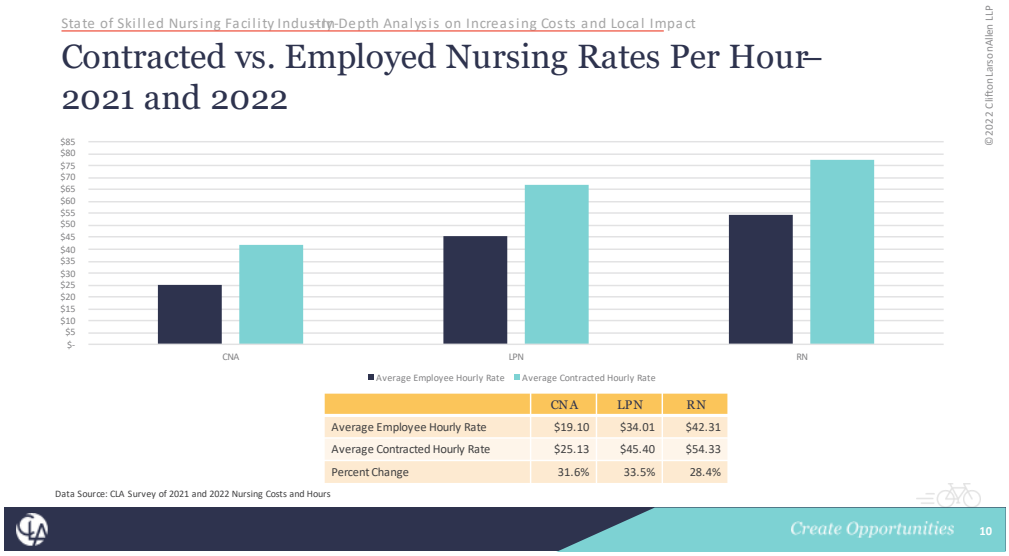


Source: https://fred.stlouisfed.org/series/CIU2026231000000I

In terms of contract labor, CLA updated its analysis of such costs using a survey of over 300 building in an updated May 2022 State of the Sector Report. Contract CNA costs were over 31% higher than in-house staff, contract LPN costs were more than 33% higher, and contract RN costs were over 28% higher than in-house costs.[13]

[13] **State of Skilled Nursing Facility Industry – In Depth Analysis of on Increasing Costs and Local Impact.** May 2022. Available at https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/AHCA%20-%20State%20of%20Skilled%20Nursing%20Facility%20Industry%20-%20In-Depth%20Analysis%20on%20Increasing%20Costs%20and%20Local%20Impact.pdf

Figure 3. Contracted vs Employed Nursing Rates Per Hour – Triple In-House Costs



	CNA	LPN	RN
Average Employee Hourly Rate	$19.10	$34.01	$42.31
Average Contracted Hourly Rate	$25.13	$45.40	$54.33
Percent Change	31.6%	33.5%	28.4%

2. *SNF Operating Environment and Public Payors – Focus on Medicare and Medicaid*

We believe several other key factors should be considered when approaching a short-term fix to our labor challenges:

- ***Labor costs within the SNF/NF sector must be covered by public payers – only a small fraction of SNF revenue is private pay or commercial insurance. SNFs also do not have the flexibility to reduce staffing without negatively impacting access or reducing occupancy to deliver quality care and meet regulatory requirements***. *In other words, SNF/NF Providers are "Price Takers" instead of "Price Setter."* Revenues only change with changes in occupancy and/or payer mix. This makes it increasingly difficult for SNFs to attract and retain front line staff when faced with especially competitive labor markets.

- ***The state and Federal governments have, over the years, added new regulatory mandates which increased SNF labor costs, often associated with administrative labor rather than direct care costs.*** These cost increases make it more challenging for SNFs to compete with employers in other industries who are able to pass on cost increases to their payers and customers.[14]

- ***It is important to note that the utilization of SNF distinct part status fell dramatically following the implementation of the SNF PPS.*** Less than 1% of SNFs reported being distinct parts in cost reports across all cost report FYEs since the implementation of the

[14] ***2022 salary increases will be the highest since 2008,"*** The Conference Board, December 2021. Available at: https://www.conference-board.org/research/economy-strategy-finance-charts/Salary-Budget-Increases-2021

SNF PPS. For this reason, we determined that it is appropriate to evaluate salary and benefit data for the entire SNF/NF provider entity instead of only the SNF portion of each provider entity.

- ***No price proxy is able to outperform the actual population-wide data trend for which the price proxy is intended to estimate.*** Thus, an analysis of actual SNF wage growth over time is one way to measure the effectiveness of a price proxy and to determine if/when an emergency add-on is needed or, under a new system an update policy is triggered.

- ***The SNF sector labor market has several distinct elements that if not appropriately captured in a price proxy can cause compression in the calculation of the price proxy index.*** Among these are (i) a high rate of turnover with "job switchers" changing employers within the sector; (ii) a workforce that is largely lower wage female, minority employees (e.g, this is projected to be a rapidly shrinking pool of workers;[15] (iii) a labor pool that is significantly impacted by external forces such as access to childcare services and relative value of unemployment benefits to wages which SNFs have attempted to address but are constrained by limited resources.

Taken together, such increases in labor costs are unsustainable without increases in the labor portion of public payors who together comprise the vast majority of SNF patient days and related revenues. Medicaid labor reimbursement amounts vary widely by state and are set by state agencies. Many states' Medicaid rate updates do not keep pace with labor costs and/or cap the amount of labor costs states will cover with state specific definitions of Allowable Costs. In 2019, Medicaid was the primary payer for 59 percent of nursing facility residents. However, the share of Medicaid-covered nursing facility residents varies widely by facility, and differences in payer mix are associated with differences in staffing levels and other facility characteristics.[16] Historically, Medicare also has not kept pace with labor cost increases. See discussion below.

3. Background for Recommendations

AHCA appreciates CMS' FY22 comments on additional monitoring for more frequent Market Basket Revise and Base efforts to reflect notable changes in SNF operating costs associated with COVID-19 (FY22 Proposed Rule Page 19969 and FY22 Final Rule page 42445). To that end, last year, CMS adjusted the price proxies for PPE to aid with increased costs which has been helpful.

At the same time, the Association recognizes that CMS did include labor adjustments in all PDPM components, and the Association also understands the SNF prospective payment system (PPS) authority is based upon patient characteristics and is not designed to address dramatic shifts in operating costs. Due to the PPS statutory limitations and continued impacts of the PHE and COVID on SNFs, AHCA respectfully requests that CMS exercise its administrative

[15] ***Why Wages Are Growing Rapidly Now— And Will Continue to in the Future.***" The Conference Board, August 2021. Available at: https://www.conference-board.org/publications/Why-Wages-Are-Growing-Rapidly
[16] ***State Policy Levers to Address Nursing Facility Staffing Issues***. MACPAC, March 2022. Available at https://www.macpac.gov/wp-content/uploads/2022/03/State-Policy-Levers-to-Address-Nursing-Facility-Staffing-Issues.pdf

authority to update its calculation approach to the labor portion of the market basket. Even establishing incremental steps aimed at calculating a more current update figure or to reflect historical gaps between price proxy estimates and actual experience would be helpful and would be closer to matching the current workforce realities.

Historically, CMS used the Employment Cost Index (ECI) for Wages and Salaries for Private Industry Workers in Nursing Care Facilities (NAICS 6231; BLS series code CIU2026231000000I) to measure price growth of this category. ECI is a measure of the change in the cost of labor, independent of the influence of employment shifts among occupations and industry categories. The total compensation series includes changes in wages and salaries and in employer costs for employee benefits.

AHCA is concerned that the ECI indexes may not accurately capture the employment costs of the nursing homes. While we recognize the Bureau of Labor Statistics has made an array of improvements in the ECI, we have identified several flaws in the ECI, as it is currently applied to the SNF market basket which we respectfully offer for CMS consideration. A research paper in the Bureau of Labor Statistics ***Monthly Labor Review*** discusses at length challenges with the ECI.[17] We discuss a few elements from this document below.

Fixed Weight Labor-related Price Proxies such as the BLS ECI for the NF sector can suffer from "compression" between Price Proxy rebases (that occur roughly every 10 years) in situations where:

- There is a high turnover rate where "job switchers" are changing employer within the same industry in order to receive increased wages (potential Lack of Individual Relevance if geographic distribution of the effect varies). The ECI does not track individuals, but rather all incumbents .within a sampled employer's selected job codes.
- There are temporary or inconsistent changes in the use of overtime and/or bonuses / incentive compensation (Novelty of Representation Bias)
- There is a rapid escalation in the use of higher cost contract labor without significant change in professional mix or quantity of labor hours (Economic Substitution Bias).
- The rapid decline in the working-age population without a bachelor's degree along with low unemployment rate is likely to generate continuous labor shortages of blue-collar and manual services workers. Thus, a tight labor market with escalating price pressure drivers that are not captured by the measure for an extended period of time.
- Government policies (e.g., unemployment) create an incentive for displaced lower income workers to exit the workforce thus exacerbating the decline in the working age population.

4. Current Market Basket Methodology

AHCA appreciates the CMS Office of the Actuary's work each year on our Market Baset update. However, we note any array of challenges with the current methodology which prevents it from

[17] Ruser, J. "***The Employment Cost Index: what is it?"*** The Monthly Labor Review, 2001, Bureau of Labor Statistics. Available at: https://www.bls.gov/opub/mlr/2001/09/art1full.pdf

addressing serious increases in operating costs such as our current workforce crisis. We offer the following commentary on the current approach:

- ***The SNF market-basket is based on a 2018 base year for the purpose of measuring the labor vs. non-labor cost inputs of 2018.*** Therefore, these base year numbers were calculated well before the pandemic and related significant labor cost increases;

- ***The Nursing Care Facility Employment Cost Index used in the setting of labor costs for the SNF-PPS "reflect[s] the cost of employing the 2012 workforce"[18] and does not consider any changes in national or state staffing requirements, staffing mix, or level of contract labor needed in 2022.*** Care delivery models have changed significantly since 2012. In addition to the points noted above, advances in best clinical practice have changed, PDPM replaced RUG IV and the pandemic has fundamentally changed staffing – particularly a new heavier reliance on contract agency staffing; and

- ***Conventional CMS re-basing of the market basket only adjusts the labor-related share and weighting of market basket components and does not take into account changes in staffing levels or overall labor costs borne by facilities.*** Related to the point above, the financial dynamics of the sector have fundamentally changed and will not return to pre-pandemic parameters.

The traditional CMS process of updating and re-weighting market basket components during re-basing does not take into consideration the continued appropriateness of increasing out of date cost surveys which form the foundation of the price proxies CMS has selected. The quarterly updates of these price proxies do not address changes in staffing levels, changes in occupational mix, increases in the use of contract labor or travel nurses or other drivers of wage rate growth such as labor market tightness and consumer inflation. The underlying assumption that staffing has not significantly changed at SNFs since 2012 must be examined to determine whether these proxies remain appropriate.

5. ***Proposed Alternative Methodology – Assistance Urgently Needed***
   Comment:

- **Provide immediate assistance we urge CMS to apply a labor-related market basket add-on associated with significant lags in labor data and ECI issues to address serious workforce shortages and challenges with the current market basket methodology. AHCA has calculated notable differences in Medicare Cost Report Direct Care Wage Data and Annual Market Basket Updates. We calculate the gap to be 5.99% in direct care labor costs and suggest spreading such an update equally over a two to three year period; and**
- **Until a more timely methodology and accurate data source to account for labor costs in the market basket updates is developed and/or identified, we urge CMS to utilize the methodology below, or similar approach, when labor costs escalate more rapidly that the current price proxy calculation method captures.**

[18] https://www.bls.gov/opub/hom/ncs/calculation.htm

AHCA recognizes the challenges associated with any methodological change and the time needed for CMS to evaluate any such proposal. However, as discussed above, the sector is struggling with unprecedented labor costs. AHCA has identified what we believe to be a straightforward approach to identifying and addressing the cumulative gap in labor adjustments that uses readily available data that can be further supported as realistic by data from other wage growth indexes such as the BLS CES and the Atlanta Federal Reserve Wage Growth Tracker.

We used our calculations to develop an annual and accumulated change in NF Direct Care Wage Rates from the initial 1998 SNF PPS Base Year through 2021 and then compared this data against the accumulated annual CMS Market Basket labor cost growth. An average Medicare Day Weighted Labor Portion percentage calculated from those published in the SNF PPS Rules since the first year of the SNF PPS was applied to the accumulated SNF Market Baskets in order to reduce the accumulated Market Basket to the Labor Portion this resulted in 5.99% which we propose be used as the basis for a labor add-on to be spread over a two to three year period.

Specifically, over the time period of 1998 to 2021, we computed both the Accumulated Cost Report SNF Direct Care & Total Wage Rate changes versus the Gross & Net CMS SNF Market Basket Labor Components. The "gap" when using accumulated Direct Care Wage Rate changes is 5.99% (Gross MB) and 8.68% (Net MB). Using the accumulated Cost Report Total Average Wage Rate change analysis showed a "gap" of 6.71% (Gross MB) and 9.40% (Net MB). See **Table 1**, below.

Table 1. Medicare Cost Report Data Differences Compared to Market Basket Updates

	Direct Care CMS HCRIS WAR vs [1]	Total CMS HCRIS WAR vs [1]
Gross CMS MB [2]	**5.99%**	**6.71%**
Net CMS MB (less FECs & TPFs) [2]	**8.68%**	**9.40%**
[1] Hours, Earnings & Weighted Average Wage Rate (WAR) Calculations from Medicare Cost Report Schedules S3 Parts 2 & 3		
[2] FFY 1998 through 2022 Market Basket, Forecast Error Corrections (FEC) & Total Productivity Adjustment Factors (TPF) from CMS Annual SNF PPS Rules		
Blended Medicare Day Weighted Market Basket Labor Component = 71.9%		

We computed the retrospective gap add-on totaling 5.99% by:

- ***Step 1***: Computing the accumulated percent change (average direct care hourly earnings from Medicare Cost Report Schedule S3, Part 2) totaling 73.6% (noted as B in Table 2, below);

- ***Step 2***: Calculating the accumulated Market Basket Per CMS PPS Rule Gross by Federal Fiscal Year, Labor Component of the SNF Market Basket Per SNF PPS Rule arriving at 65.266% (noted as C in Table 2, below); and

- ***Step 3***; Multiply the difference between C and B by the blended average Medicare Day Weighted labor portion of the market basket of 71.9% (noted at C1 in Table 2 below)

The equation is as follows:

(65.266% - 73.6%)*71.9% = -- 5.99%

See ***Table 2***, below, for detailed calculations.

Of note, we recognize SNF Medicare Cost Reports are not audited by the federal government. However, we believe the year over year trends in the data present evidence of trend validation and HCRIS data analysis aligns with other calculations of accumulated raw percent changes. See Figure 4. Of note, of the measures below, the ECI-driven measures differ notably.

Figure 4. Accumulated Raw % Change in Hourly Wage Rates, 1998 – 2021

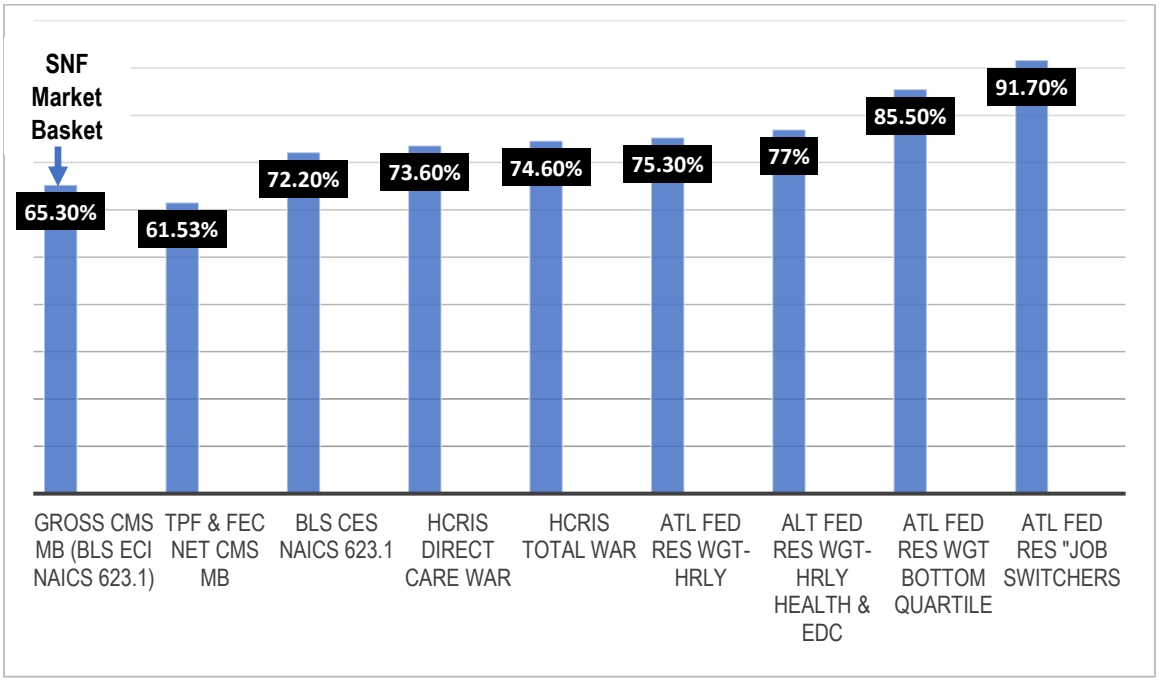


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Table 2. Detailed Calculations for Temporary Add-On

YEAR	YEAR DESCRIPTION	FFY	Count of Medicare Cost Reports in Avg Rate per Hour Calculation	Medicare Days per CMS HCRIS	Market Basket per CMS SNF PPS Final Rules - GROSS by FFY: Gross SNF Market Basket per CMS SNF PPS Rule	Accum Gross SNF Market Basket	Labor Component of SNF Market Basket per CMS SNF PPS Rule	Market Basket per CMS SNF PPS Final Rule - NET (w/o FECs and MPAFs) by FFY: SNF Market Basket Net of MPAF per CMS SNF PPS Rule	Accum SNF Market Basket per CMS SNF PPS Rule Net of MPAF & FEC	Multi-Factor Productivity Adjustment Factor (MPAF) & Forecast Error Correction (FEC)		Based on BLS CES Detail Average Annual Hourly Wage Rate for NAICS 623 Subcomponent 100 (NFs) & Type Code 08 (Productive & Non-Supervisory) (CEU6562310008): Average Hourly Earnings of Production & Non-Supervisory Employees at Nursing Facilities - Not Seasonally Adjusted	% CHANGE (Avg Hrly Earnings of Productive & Non-Supv NF Employees not Seasonally Adjusted)	ACCUM % CHANGE (Avg Hrly Earnings of Productive & Non-Supv NF Employees not Seasonally Adjusted)	Direct Care Wage Rate per Medicare Cost Report Schedule S3 Part 2: Medicare Cost Report Schedule S3 Part 2 Direct Care Average Hourly Wage Rate	% CHANGE (Avg Direct Care Hrly Earnings from Medicare Cost Report Schedule S3 Part 2)	ACCUM % CHANGE (Avg Direct Care Hrly Earnings from Medicare Cost Report Schedule S3 Part 2)	Total Wage Rate per Medicare Cost Report Schedule S3 Part 2: Medicare Cost Report Schedule S3 Part 2 TOTAL Average Hourly Wage Rate	PERCENT CHANGE (Avg TOTAL Hrly Earnings from Medicare Cost Report Schedule S3 Part 2)	ACCUM PERCENT CHANGE (Avg TOTAL Hrly Earnings from Medicare Cost Report Schedule S3 Part 2)
0					1.75%			1.75%				$10.09			$ 10.93			$ 10.71		
1	1998 to 1999	1999	11,443	32,279,682	2.10%	3.85%	75.888%	2.10%	3.85%			$10.51	4.163%		$ 11.56	5.767%	5.767%	$ 11.04	3.084%	3.084%
2	1999 to 2000	2000	11,912	35,545,237	3.10%	6.95%	77.545%	3.10%	6.95%			$11.08	5.423%	9.586%	$ 12.29	6.317%	12.084%	$ 11.93	8.085%	11.170%
3	2000 to 2001	2001	11,815	38,465,770	3.32%	10.27%	77.870%	3.32%	10.27%	0.00%		$11.69	5.505%	15.091%	$ 12.97	5.536%	17.620%	$ 12.82	7.481%	18.650%
4	2001 to 2002	2002	12,130	43,357,888	3.30%	13.57%	75.379%	3.30%	13.57%	0.00%		$12.13	3.764%	18.855%	$ 13.57	4.626%	22.245%	$ 13.48	5.149%	23.799%
5	2002 to 2003	2003	12,138	46,713,391	3.10%	16.67%	76.128%	3.10%	16.67%	0.00%		$12.52	3.215%	22.070%	$ 14.01	3.263%	25.509%	$ 13.91	3.144%	26.943%
6	2003 to 2004	2004	12,177	49,738,578	3.00%	19.67%	76.372%	6.26%	22.93%	3.26%	FEC	$12.75	1.837%	23.907%	$ 14.42	2.886%	28.395%	$ 14.31	2.906%	29.849%
7	2004 to 2005	2005	12,219	52,443,636	2.80%	22.47%	75.776%	2.80%	25.73%	0.00%		$13.08	2.588%	26.496%	$ 14.83	2.873%	31.267%	$ 14.73	2.920%	32.769%
8	2005 to 2006	2006	12,329	53,906,151	3.10%	25.57%	75.922%	3.10%	28.83%	0.00%		$13.51	3.287%	29.783%	$ 15.34	3.463%	34.730%	$ 15.23	3.379%	36.149%
9	2006 to 2007	2007	12,318	52,936,364	3.10%	28.67%	75.839%	3.10%	31.93%	0.00%		$13.85	2.517%	32.300%	$ 15.98	4.177%	38.907%	$ 15.81	3.856%	40.004%
10	2007 to 2008	2008	13,431	60,839,412	3.30%	31.97%	70.152%	3.30%	35.23%	0.00%		$14.37	3.755%	36.054%	$ 16.34	2.194%	41.101%	$ 16.19	2.374%	42.379%
11	2008 to 2009	2009	13,706	62,660,561	3.40%	35.37%	69.783%	3.40%	38.63%	0.00%		$14.97	4.175%	40.230%	$ 16.65	1.926%	43.027%	$ 16.50	1.921%	44.300%
12	2009 to 2010	2010	13,748	63,379,491	2.20%	37.57%	69.840%	2.20%	40.83%	0.00%		$15.26	1.937%	42.167%	$ 16.95	1.789%	44.816%	$ 16.84	2.085%	46.385%
13	2010 to 2011	2011	12,628	59,431,589	2.30%	39.87%	69.310%	1.70%	42.53%	-0.60%	MPAF	$15.26	0.000%	42.167%	$ 17.33	2.274%	47.090%	$ 17.20	2.129%	48.514%
14	2011 to 2012	2012	13,980	63,170,660	2.70%	42.57%	68.690%	1.70%	44.23%	-1.00%	MPAF	$15.17	-0.590%	41.577%	$ 17.57	1.354%	48.444%	$ 17.44	1.366%	49.880%
15	2012 to 2013	2013	13,987	62,861,788	2.50%	45.07%	68.383%	1.80%	46.03%	-0.70%	MPAF	$15.46	1.912%	43.489%	$ 17.80	1.321%	49.765%	$ 17.68	1.399%	51.279%
16	2013 to 2014	2014	13,927	61,087,992	2.30%	47.37%	69.545%	1.30%	47.33%	-1.00%	MPAF	$15.58	0.776%	44.265%	$ 18.14	1.891%	51.656%	$ 18.02	1.938%	53.217%
17	2014 to 2015	2015	13,995	59,749,159	2.50%	49.87%	69.180%	2.00%	49.33%	-0.50%	MPAF	$15.85	1.733%	45.998%	$ 18.52	2.102%	53.758%	$ 18.40	2.060%	55.277%
18	2015 to 2016	2016	14,051	58,028,898	2.30%	52.17%	69.100%	1.20%	50.53%	-1.10%	MPAF	$16.41	3.533%	49.531%	$ 19.11	3.193%	56.952%	$ 19.11	3.879%	59.156%
19	2016 to 2017	2017	14,304	55,493,258	2.70%	54.87%	68.800%	2.40%	52.93%	-0.30%	MPAF	$16.93	3.169%	52.700%	$ 19.72	3.201%	60.153%	$ 19.54	2.234%	61.389%
20	2017 to 2018	2018	14,275	53,594,510	2.60%	57.47%	70.800%	2.00%	54.93%	-0.60%	MPAF	$17.27	2.008%	54.708%	$ 20.43	3.595%	63.748%	$ 20.19	3.363%	64.752%
21	2018 to 2019	2019	14,269	50,533,826	2.80%	60.27%	70.500%	2.00%	56.93%	-0.80%	MPAF	$18.14	5.038%	59.746%	$ 20.94	2.515%	66.262%	$ 20.74	2.709%	67.461%
22	2019 to 2020	2020	14,234	51,011,346	2.80%	63.07%	70.900%	2.40%	59.33%	-0.40%	MPAF	$19.21	5.899%	65.644%	$ 22.14	5.725%	71.987%	$ 21.90	5.602%	73.063%
23	2020 to 2021	2021	2,147	51,011,346	2.20%	65.27%	71.300%	2.20%	61.53%	0.00%		$20.48	6.611%	72.256%	$ 22.50	1.612%	73.600%	$ 22.24	1.541%	74.604%
										-3.74%										
						65.266% C			61.526% D					72.256% A			73.600% B			74.604%
						-6.989%			-10.729%											
	Blended Average Labor Portion of the Market Basket					71.9% C1			71.9% D1											

PROPOSED: Historical Market Basket Medicare Day Weighted Labor Component Forecast Error Correction

-5.02% Gross CMS MB (BLS ECI) vs BLS CES	(C-A)*C1
-5.99% Gross CMS MB (ECI) vs HCRIS Direct Care WAR	(C-B)*C1
-6.71% Gross CMS MB (BLS ECI) vs HCRIS TOTAL WAR	(C-E)*C1
-7.71% Net CMS MB (BLS ECI) vs BLS CES	(D-A)*D1
-8.68% Net CMS MB (ECI) vs HCRIS Direct Care WAR	(D-B)*D1
-9.40% Net CMS MB (BLS ECI) vs HCRIS TOTAL WAR	(D-E)*D1

Based on BLS CES Detail Average Annual Hourly Wage Rate for NAICS 623 Subcomponent 100 (NFs) & Type Code 08 (Productive & Non-Supervisory)

Finally, AHCA urges CMS to conduct this exercise regularly and set a trigger point for one-time labor related price proxy forecast adjustments to market basket to address labor cost shifts which are not captured in the current price proxy methodology and data source (see below).

6. ***Proposed Longer Term Solutions: Evaluate Options Other Than the ECI. Specially, AHCA recommends convening a provider technical expert panel to discuss a longer range approach to collecting and imputing more appropriate and more current data for market basket labor update calculations in an attempt to encompass factors not currently captured by currently available price proxies.***

The ECI is specifically designed to capture the changes in the cost of employing a set group of workers over time and to ignore actual changes in the workforce. Because the workforce does change in size and composition over time, the ECI does not measure the actual labor costs for employers such as SNFs.

Most recently, BLS web site announced changes to the Standard Occupational Classification system weights that are used in the computation of the ECI. The changes will update the Standard Occupational Codes (SOC) information from 2010 to 2018. We are concerned that they are removing a number of Occupational Classifications that are of importance to health care providers including Nursing Aide, Home Health Aide and Respiratory Therapy Techs. See below for details for the key PAC/LTC SOC codes from 2010 that are being deleted in the 2018 data.

Figure 4 . Deleted Occupational Classification Codes

Detailed	29-2054	Respiratory Therapy Technicians
Detailed	29-2071	Medical Records and Health Information Technicians
Broad	29-9010	Occupational Health and Safety Specialists and Technicians
Detailed	29-9011	Occupational Health and Safety Specialists
Detailed	29-9012	Occupational Health and Safety Technicians
Minor	31-1000	Nursing, Psychiatric, and Home Health Aides
Broad	31-1010	Nursing, Psychiatric, and Home Health Aides
Detailed	31-1011	Home Health Aides
Detailed	31-1013	Psychiatric Aides
Detailed	31-1014	Nursing Assistants

AHCA has detailed analytic materials including raw data we would happily share with the CMS Office of the Actuary as it considers our comments.

Section III. Wage Index Cap Permanency
AHCA Position: AHCA supports the wage index decrease cap permanency.

AHCA greatly appreciates CMS' efforts to offer more stability to the annual wage index updates and supports the proposal. However, we urge CMS to work with the sector in future on further helpful steps to offer more stability. Many CBSAs experienced significant drops just below the 5% mark this year. See ***Table 1***. SNFs struggle annually with unpredictable decreases and challenges with working with hospitals on accurate cost report completion to aid with more accurate wage index updates. The cap is a step towards a broader solution – a SNF specific wage index. We would welcome the opportunity to work with CMS on larger picture solutions.

Table 1. CBSAs Impacted Both Above and Slightly Below the 5% Cap

CBSA Code	Urban Area	Constituent Counties		Percent Change
20740	Eau Claire, WI	Chippewa County, Wisconsin		-8.65%
14100	Bloomsburg-Berwick, PA	Columbia County, Pennsylvania		-8.02%
11500	Anniston-Oxford, AL	Calhoun County, Alabama		-7.56%
39540	Racine, WI	Racine County, Wisconsin		-7.29%
13740	Billings, MT	Carbon County, Montana		-7.23%
99927	Montana		27	-6.99%
19340	Davenport-Moline-Rock Island, IA-IL	Henry County, Illinois		-6.77%
38220	Pine Bluff, AR	Cleveland County, Arkansas		-6.52%
99935	North Dakota		35	-6.41%
31340	Lynchburg, VA	Amherst County, Virginia		-6.07%
32420	Mayagüez, PR	Hormigueros Municipio, Puerto Rico		-5.76%
37100	Oxnard-Thousand Oaks-Ventura, CA	Ventura County, California		-5.72%
48140	Wausau-Weston, WI	Lincoln County, Wisconsin		-5.39%
29420	Lake Havasu City-Kingman, AZ	Mohave County, Arizona		-5.35%
10380	Aguadilla-Isabela, PR	Aguada Municipio, Puerto Rico		-5.30%
19780	Des Moines-West Des Moines, IA	Dallas County, Iowa		-5.16%
44100	Springfield, IL	Menard County, Illinois		-5.07%
12020	Athens-Clarke County, GA	Clarke County, Georgia		-5.04%
45540	The Villages, FL	Sumter County, Florida		-4.75%
48864	Wilmington, DE-MD-NJ	Cecil County, Maryland		-4.74%
35100	New Bern, NC	Craven County, North Carolina		-4.73%
22420	Flint, MI	Genesee County, Michigan		-4.63%
41660	San Angelo, TX	Irion County, Texas		-4.47%
27180	Jackson, TN	Chester County, Tennessee		-4.36%
25620	Hattiesburg, MS	Covington County, Mississippi		-4.35%
13380	Bellingham, WA	Whatcom County, Washington		-4.19%
99952	Wisconsin		52	-4.15%
99946	Utah		46	-4.12%
38660	Ponce, PR	Adjuntas Municipio, Puerto Rico		-4.11%
40484	Rockingham County-Strafford County, NH	Rockingham County, New Hampshire		-4.07%
27980	Kahului-Wailuku-Lahaina, HI	Maui County, Hawaii		-4.00%

Section IV. Parity Adjustment

On October 1, 2019, CMS implemented the new skilled nursing facility prospective payment system (SNF PPS) case-mix classification model called the Patient Driven Payment Model (PDPM). When finalizing PDPM, CMS stated that this new payment model would be implemented in a budget neutral manner, meaning that the transition to this new payment model would not result in an increase or decrease in aggregate SNF spending.

In the fiscal year (FY) 2023 SNF PPS proposed rule, CMS discussed the lengths taken to address concerns raised in last year's rulemaking in addressing data challenges associated with the impact of COVID-19 on costs and data trends. CMS is proposing a modified *"Control-Period-based Adjustment Factor"* approach to establishing an accurate parity adjustment factor. After applying the new approach, CMS continues to note higher than expected PDPM spending, indicating the transition from RUG IV to PDPM was not budget neutral and requires an updated parity adjustment.

CMS is proposing an immediate 4.6 percent parity adjustment to begin in FY 2023, to be applied equally across all components, and with no transition period. However, CMS is requesting comments on

1. The modified parity adjustment approach,
2. Whether the adjustment should be applied equally across all components, and
3. If stakeholders believe delayed implementation or a phase-in period is still warranted.

AHCA Parity Adjustment Recommendations:

- **To mitigate for COVID *"spillover"* effects that remain despite the improvements included in the proposed CMS *"Control-Period-based Adjustment Factor"* parity adjustment approach, we recommend that CMS further evaluate the data to also exclude the months of April, May, August, and September 2021 from the parity adjustment calculations.**
    - **We believe this approach will mitigate most to the remaining *"spillover"* effects and will result in an additional 0.1 to 0.2 percent reduction below the currently proposed 4.6 percent parity adjustment amount.**
- **AHCA recommends that CMS adopt, as proposed, to apply the final recalibrated parity adjustment across all PDPM CMIs in equal measure.**
- **To assure some predictability and stability to the sector, AHCA recommends that CMS should lock in the parity adjustment amount this year after considering public comments regarding the appropriate percentage methodology, and then phase in the reduction evenly over 3 years (e.g., 1.5 percent per year).**
    - **Due to the state of the sector, we strongly oppose a one-time parity adjustment being applied in FY 2023. AHCA believes the proposed one-time**

parity adjustment on FY 2023 will exacerbate staffing shortages and cause serious harm to beneficiary access to quality care.

AHCA appreciates the deliberative approach the Agency has taken to date to best assure that aspects of the impacts of the COVID-19 public health emergency (PHE) on the PDPM payments are fully mitigated to best assure that any finalized parity adjustment determination does not result in an overcorrection that could negatively impact beneficiary access to care. We want to note our appreciation that the Agency followed through with addressing many of the questions AHCA raised in response to last year's proposed rule related to potential COVID *"spillover"* effects on the parity adjustment analysis data. Overall, we believe this year's proposal is an improved approach, however we continue to believe that there is COVID *"spillover"* that has yet to be accounted for.

***"Spillover"* occurs in non-COVID patient CMIs when minimum data set (MDS) patient assessment item patterns change from what would have occurred if not for the pandemic.** For example, the pandemic environment of mandatory isolation and visit restrictions resulted in more mood and mental disorders and lower functional mobility reported. These factors significantly impact PDPM component CMIs, particularly Nursing.

With that in mind, we are taking the opportunity in this comment letter to discuss key findings from our parity adjustment analysis that suggest that some COVID-19 *"spillover"* effects remain, including during the early phase of the Delta variant surge beginning in August and September 2021, that justify our request for CMS to consider further refinement, including excluding data from other months in FY 2021 from the CMS parity adjustment analysis. The following parity adjustment comments focus on these topics.

- **AHCA Approach to Replicating the CMS Parity Adjustment Calculation**
- **AHCA Approach to Assessing the Adequacy of the proposed *"Control-Period-based Adjustment Factor"* Approach**
- **AHCA Results Indicating PDPM Component CMIs Are Skewed During COVID Surges**
- **AHCA Results Suggesting that the proposed *"Control-Period-based Adjustment Factor"* is adequate to account for COVID *"spillover"* effects**
- **AHCA Results Suggesting that the proposed *"Control-Period-based Adjustment Factor"* is not adequate to account for COVID *"spillover"* effects**
- **AHCA Recommendations Related to PDPM Parity Adjustment Amount**
- **AHCA Recommendations About Whether the Adjustment Should be Applied Equally Across all Components**
- **AHCA Recommendations Related to Delay or Phase-In of Parity Adjustment Amount**

1. AHCA Approach to Replicating the CMS Parity Adjustment Calculation

AHCA replicated the CMS proposed *"Control-Period-based Adjustment Factor"* methodology for calculating the parity adjustment using FY 2020 and FY 2021 claims data to estimate the parity adjustment. Specifically, we implemented the following CMS Guidance:

- Calculate expected total payments for the first 6 months of FY 2020 and the last 6 months of FY 2021 using the percentage of stays in each RUG-IV group in FY 2019
- Multiply percentage of stays in each RUG-IV group in FY 2019 by the total number of days of service for the first 6 months of FY 2020 and the last 6 months of FY 2021
- Multiply by the per diem rates, inflating by the market basket update factor (and accounting for AIDS add-on and urban versus rural status).
- Calculate actual payments for the first 6 months of FY 2020 and the last 6 months of FY 2021 based on case-mix, taking into account the variable per diem amounts, AIDS add-on, and urban versus rural status.

Sensitivity analyses also tested the exclusion of August and September 2021.

AHCA Findings

Our findings are consistent with the CMS reported results in the proposed rule. Specifically, our analysis using the proposed *"Control-Period-based Adjustment Factor"* resulted in a similar 0.4 percent reduction of the parity adjustment estimate compared to the results from the approach proposed in the FY 2022 proposed rule. However, as discussed in the following case-mix changes discussion, we note several trends that suggest the COVID some *"spillover"* effects remain in the proposed *"Control-Period-based Adjustment Factor"* that require CMS to consider excluding additional monthly data from FY 2021 from the analysis population. **Based on our sensitivity analysis which excluded August and September claims, we estimate that such efforts applied to our recommended exclusion months of April, May, August, and September 2021 may reduce the proposed 4.6 percent parity adjustment estimate factor by an additional 0.1 to 0.2 percent.**

2. AHCA Approach to Assessing the Adequacy of the proposed "Control-Period-based Adjustment Factor" Approach

In this section we discuss the general approach AHCA took to examine changes in PDPM case mix for the proposed PDPM parity adjustment population as well as changes related to beneficiary demographics and social determinants of health during the COVID-19 PHE.

2.a. Examining Changes in Case-Mix

AHCA examined trends in the case-mix indices (CMIs) of all beneficiaries treated in SNFs since the transition to PDPM based on the Health Insurance Prospective Payment System (HIPPS) codes recorded on the Medicare claims. This includes a month-by-month analyses of Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SLP), Nursing, and Non-therapy Ancillary (NTA) case-mix indices from the transition to the PDPM in

October 2019 through FY 2021. Many of these trends were also examined in parallel with trends in COVID-19 cases by state using the CDC Case Task Force dataset.

While the analyses of CMIs provides information on the characteristics at the time of admission to the SNF, AHCA also examined case-mix by looking at CMS Hierarchical Condition Categories (HCCs) and HCC risk scores. HCCs were constructed using 12 months of Medicare claims prior to admission to the SNF. Beneficiaries with less than 12 months of data were assigned a new enrollee risk score based on demographic characteristics alone, no HCCs are available for this subset of the sample. Since HCCs are based on diagnosis coding alone, this analysis provides important independently reported information on the severity of the beneficiary population admitted to SNFs in addition to the assessment-based case-mix indices.

We note that in all of the following claim-based analyses, AHCA was able to simulate the proposed parity adjustment population data by excluding claims for patients with a claim COVID diagnosis and/or the presence of the Section 1135 waiver 'DR' claim Condition Code.

2.b. Examining Changes in Demographics and Social Determinants of Health

Due to observed changes in hospital discharge patterns to SNFs during the COVID-19 PHE that may not return to the FY 2109 baseline, AHCA is concerned about the potential impacts of a parity adjustment on historically disadvantaged and underserved populations if the parity adjustment approach does not account for a *"new normal"* of SNF admissions case mix acuity. In our analyses we explored changes in the demographics and other social determinants of health for beneficiaries receiving care in SNFs from FY 2019 - 2021. The FY 2020 SNF enrollment was further identified as pre-pandemic (October 2019 – February 2020) and pandemic (March 2020 – September 2020). Age, zip-code, race, and dual status were identified directly from the Medicare claims data.

AHCA used beneficiary zip code from the Medicare FFS claims to link data with the American Community Survey (ACS) characteristics. Examining the characteristics of beneficiaries in his or her ZIP code of residence provides a better understanding of the communities and beneficiaries receiving care at SNFs prior to and during pandemic.

The following ACS variables were included in this analysis:

- median income,
- percent of the population (age 25+) with given education attainment (completed high school or completed bachelor's degree), and
- percent of residents with income below 200 percent FPL

The MDS also served as a source of data for understanding changes in the characteristics of beneficiaries over time. MDS assessment items can suggest a shift in patient acuity for admissions during the PHE, particularly during the CMS proposed "Control Period" of lower COVID cases. One limitation of the AHCA MDS-only analysis of the most recently available

public data files we examined is that we were unable to exclude SNF PPS MDS assessments for stays under a section 1135 waiver. Therefore, while we were able to exclude assessments for COVID patients, we were unable to exclude those assessments for patients without COVID but with a section 1135 waiver, which may result in some skewing of our results. However, given that CMS noted in the proposed rule that the overwhelming percentage of SNF admissions during the PHE remained form traditional 3-day qualifying inpatient hospital stays (87 FR 22739 excerpt below), we believe the significant MDS item "spillover" effects we describe below most likely reflect real impacts, and are not an artifact of not being able to exclude Section 1135 waiver patient MDS assessments from our MDS-only analyses.

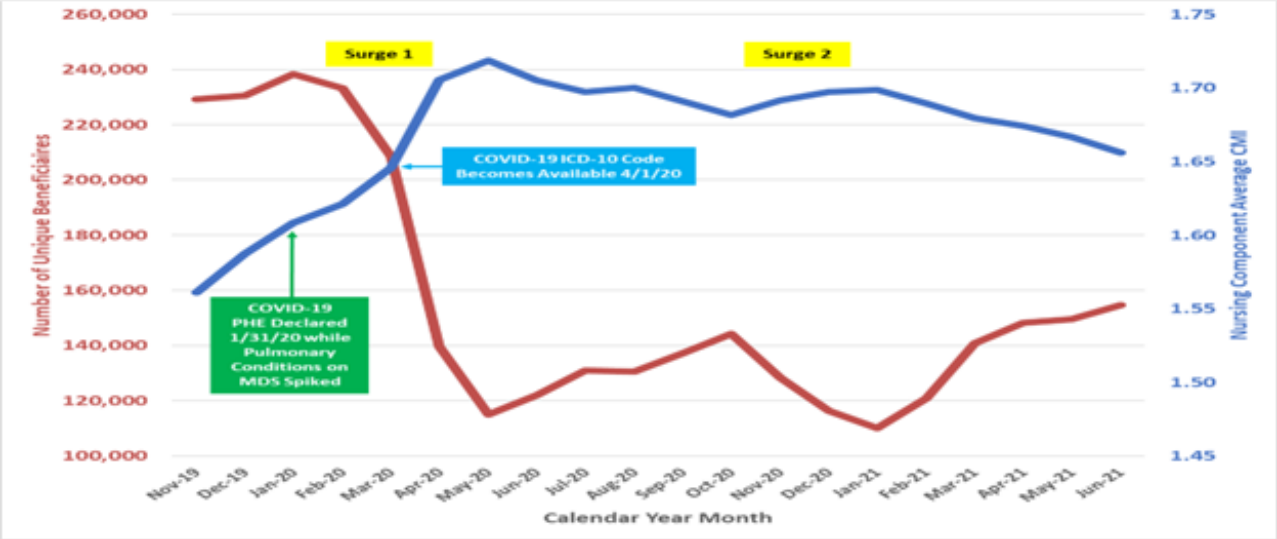
> *"As compared to prior years, when approximately 98 percent of SNF beneficiaries had a qualifying prior hospital stay, approximately 86 percent and 81 percent of SNF beneficiaries had a qualifying prior hospitalization in FY 2020 and FY 2021, respectively. These general statistics are important, as they highlight that while the PHE for COVID–19 certainly impacted many aspects of nursing home operations, the large majority of SNF beneficiaries entered into Part A SNF stays in FY 2020 and FY 2021 as they would have in any other year; that is, without using a PHE-related modification, with a prior hospitalization, and without a COVID–19 diagnosis."*

AHCA also examined trends in demographics and social determinants of health across the analysis period and assessed correlation with COVID-19 cases by state area. COVID-19 case data was obtained from the CDC Case Task Force dataset which has a record of total cases by state from January 2020 through April 2022.

3. AHCA Results Indicating PDPM Component CMIs Are Skewed During COVID Surges

Figure 1 highlights an AHCA analysis of two PDPM data trends from claims data suggesting that the PDPM data CMS proposed using for its parity adjustment approach is not like the 2019 comparison population, and that COVID *"spillover"* effects also upwardly skewed PDPM CMIs into 2021. The red line in the figure shows claims data trends for SNF Part A admissions between November 2019 and June 2021 after a 3-day qualifying hospital stay that did not have a COVID-19 diagnosis. The blue line shows the shifting PDPM Nursing component average CMIs for urban providers during this same period.

Figure 1. SNF Admission and Nursing Component CMI Trends (Non-COVID/Non-Waiver Claims)



As depicted by the red line, SNF non-COVID/non-waiver admissions from a 3-day inpatient stay dropped over 50 percent between January and May 2020, with only a partial recovery through June 2021. This corresponds to a suspension of elective surgeries, and a shift to home care for low acuity patients reluctant to enter a SNF, bottoming out as expected during the two COVID surges during this period. It is unclear whether this shift in admission volume and patient acuity mix patterns is temporary, or if it represents a permanent *"new normal"* [1],[2],[3]. Throughout the pandemic, hospitals have been discharging fewer and sicker patients to SNFs than in 2019.

Additionally, the blue line in the chart shows ongoing COVID *"spillover"* effects elevating CMIs beyond pre-pandemic levels. As depicted by the green box, Nursing CMIs shifted upwards even before the PHE onset. During this period MDS assessments showed a spike in reported pulmonary conditions, the first COVID cases and deaths in SNFs occurred, and quarantines started. The blue box indicates another upward CMI shift in April when the full force of the pandemic hit. By July 2021, when most patients were vaccinated and COVID cases were lower, the CMIs of non-COVID patients also trended towards pre-pandemic levels but had not stabilized at a *"new normal"*.

Notable is that the Nursing component CMIs show an inverse relationship to admission trend, suggesting that during COVID surges hospitals were more reluctant to discharge lower acuity patients to SNFs, increasing the proportion of higher acuity patients. These numbers could approach pre-pandemic levels during an endemic phase of COVID where there is less anxiety and fewer restrictions impacting visitations and mobility. It's less certain if hospital discharges return to pre-pandemic patterns.

The claim trends in Figure 1 do not include the last two months of FY 2021, during which the COVID-19 Delta variant surge occurred. The following comments provide results of AHCA analyses that include all months of FY 2021.

4. AHCA Results Suggesting that the proposed "Control-Period-based Adjustment Factor" is adequate to account for COVID "spillover" effects

We identified five beneficiary characteristics, demographics, or social risk factors that demonstrated negative COVID *"spillover"* effects early in the PHE but appeared to return to pre-PHE levels. These five factors are:

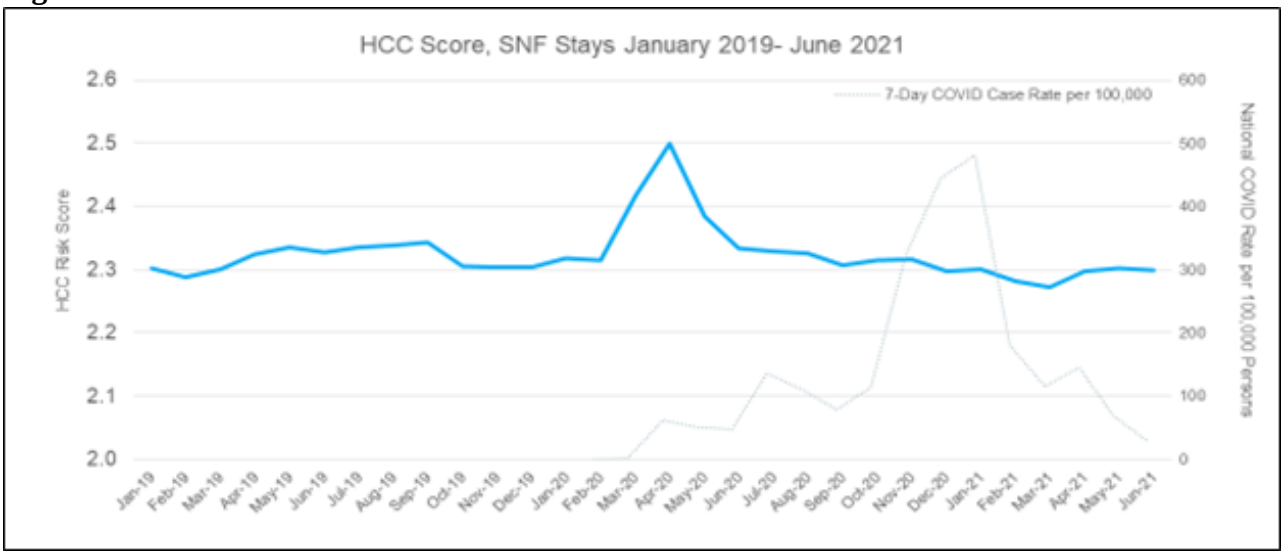
- *HCC Risk Scores*
- *ESRD Status*
- *English Proficiency*
- *Education Level, and*
- *Poverty Level*

We believe that the proposed *"Control-Period-based Adjustment Factor"* methodology mitigates the impacts of these five factors since the months of the observed shifts are proposed to be excluded from the parity adjustment analysis. Below are comments specific to each of these factors:

HCC Risk Scores

As depicted in the blue line in Figure 2, after removing claims for SNF stays with a COVID-19 diagnosis and SNF stays admitted through the waiver, there was a significant jump in the CMS HCC risk score for beneficiary stays at the start of the COVID-19 pandemic but returned to pre-pandemic averages by the fall of 2020. These results clearly indicate that early in the pandemic, the underlying complexity of non-COVID/non-waiver patients admitted to SNFs following a traditional 3-or-more day qualifying hospital stay shifted dramatically towards patients with multiple chronic conditions in addition to the condition that triggered the qualifying inpatient hospital stay.

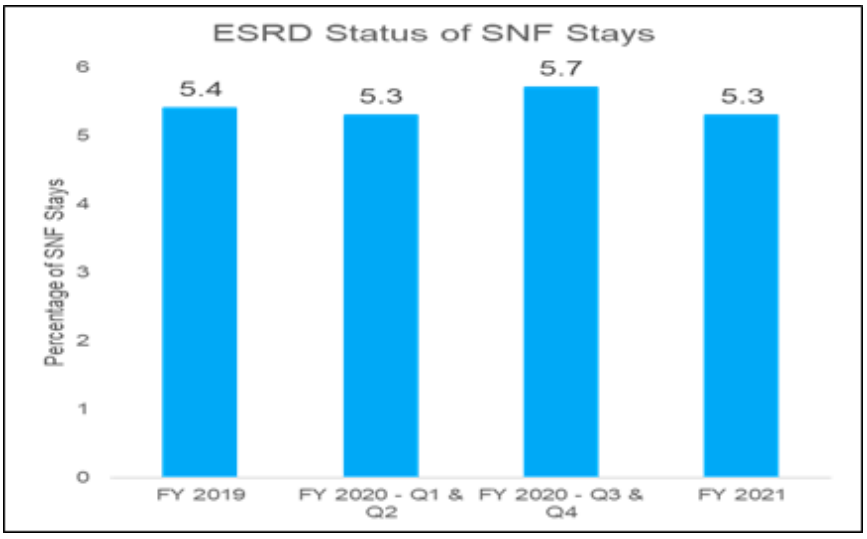
Figure 2. HCC Risk Score Trends of SNF Admissions



ESRD Status

When we evaluated claims for the distribution of Part A stays initiated for beneficiaries with end-stage renal disease (ESRD) status (Figure 3) there was a jump in the proportion patients with ESRD status for beneficiary stays at the start of the COVID-19 pandemic. However, the proportion returned to pre-PHE levels in FY 2021. We believe this was driven primarily by the challenges for patients to obtain dialysis services on an outpatient basis in the early part of the PHE when there were the most significant infection control restrictions for transportation providers and ESRD centers. Many beneficiaries requiring dialysis were able to obtain the necessary frequent and lengthy dialysis services on a more regular basis when residing in a SNF rather than at home.

Figure 3. Percent ESRD Status Patients Admissions Increased With the Onset of COVID and Returned to Baseline in FY 2021

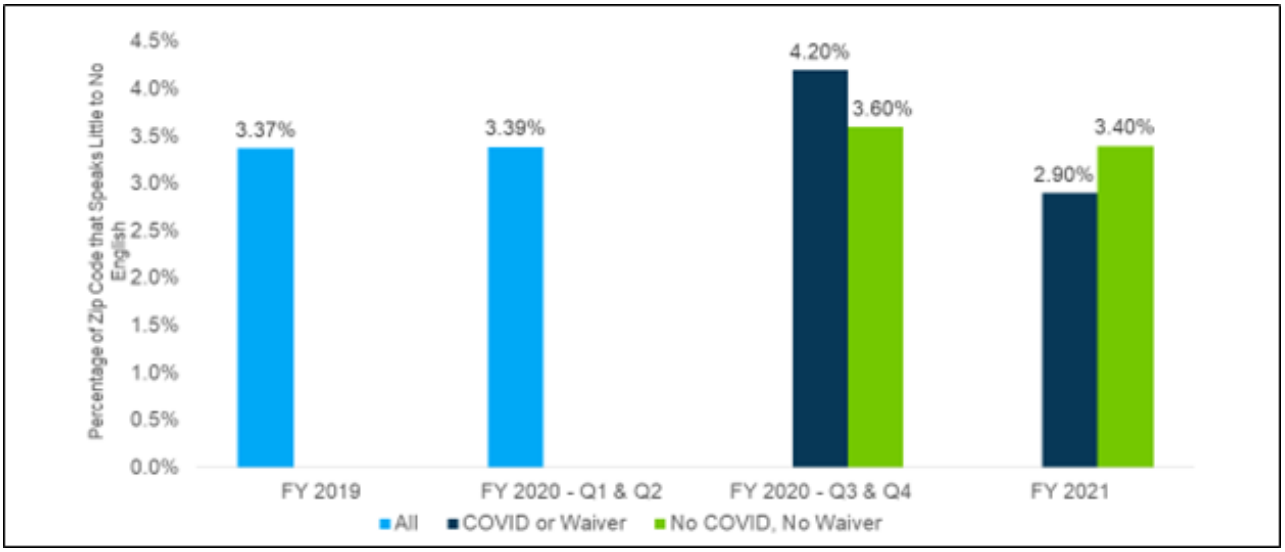


English Proficiency

When we evaluated the distribution of Part A stay claims initiated for beneficiaries from zip codes where people spoke little or no English (Figure 4) there was a jump in the proportion patients from these areas for beneficiary stays at the start of the COVID-19 pandemic. However, the proportion returned to pre-PHE levels in FY 2021.

Although unrelated to the PDPM parity adjustment discussion, we also included in Figure 4 the distribution of Part A stays initiated for beneficiaries from zip codes where people spoke little or no English who were admitted with a COVID diagnosis or under a Section 1135 waiver. We found it interesting that the proportion of this population spiked early in the PHE but dropped significantly in FY 2021. This could partially reflect a consistency with reports that COVID-19 had a disproportionate impact on the non-English speaking population early in the pandemic. We have not been able to ascertain why this proportion dropped significantly below baseline in FY 2021.

Figure 4. Percent of SNF Residents From Areas Where People Spoke Little to No English Increased At Pandemic Onset and Returned to Baseline in FY 2021

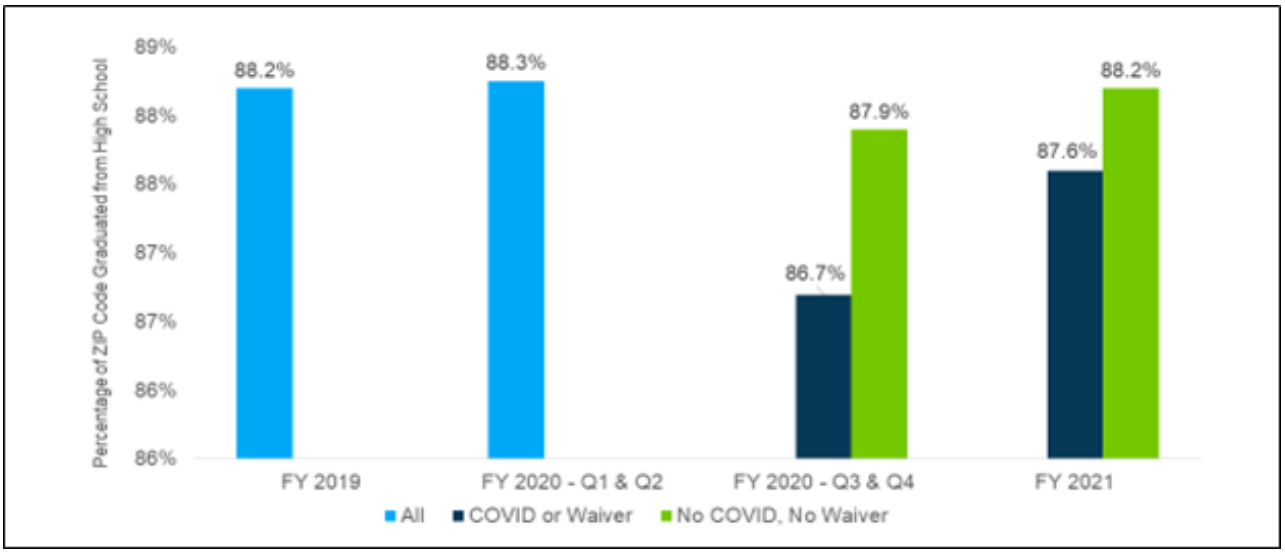


Education Level

When we evaluated the distribution of Part A claim stays initiated for beneficiaries from zip codes with higher high school graduation rates (Figure 5) there was a drop in the proportion patients from these areas for beneficiary stays at the start of the COVID-19 pandemic. However, the proportion returned to pre-PHE levels in FY 2021.

Although unrelated to the PDPM parity adjustment discussion, we also included in Figure 5 the distribution of Part A stays initiated for beneficiaries from zip codes with higher high school graduation rates who were admitted with a COVID diagnosis or under a Section 1135 waiver. We found it interesting that the proportion of this population dropped significantly early in the PHE and did not receiver completely in FY 2021. This could partially reflect a consistency with reports that COVID-19 had a disproportionate impact on less-educated individuals early in the pandemic. We have not been able to ascertain why this proportion would remain below baseline in FY 2021.

Figure 5. Percent of SNF Residents From Zip Codes with Higher High School Graduation Rates Decreased At Pandemic Onset and Returned to Baseline in FY 2021

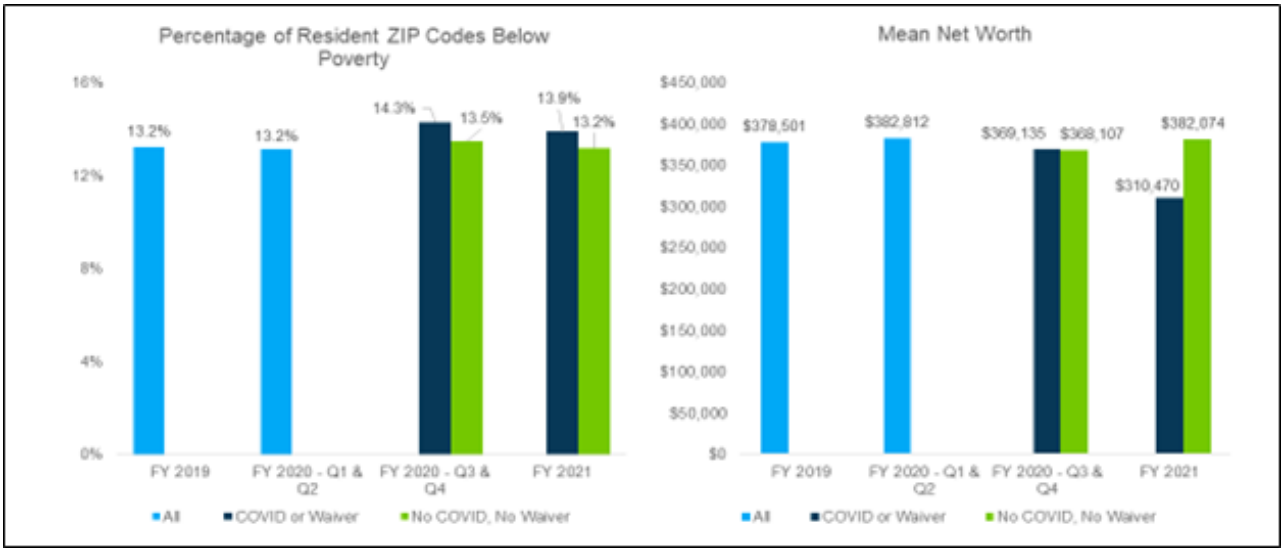


Poverty Level

When we evaluated the distribution of Part A claim stays initiated for beneficiaries from zip codes with higher poverty rates, and the mean net worth of these individuals (Figure 6) there was a slight increase in the proportion patients from these areas for beneficiary stays at the start of the COVID-19 pandemic. However, the proportion returned to pre-PHE levels in FY 2021. Of those admitted from these areas, the mean net worth dropped early in the PHE and then returned to baseline in FY 2021.

Although unrelated to the PDPM parity adjustment discussion, we also included in Figure 6 the distribution of Part A stays initiated for beneficiaries from zip codes with higher poverty levels who were admitted with a COVID diagnosis or under a Section 1135 waiver. We found it interesting that the proportion of this population increased early in the PHE and did not recover completely in FY 2021. Additionally, while the mean net worth of these individuals dropped early in the pandemic similar to the proposed parity adjustment population, the mean net worth of persons in higher poverty areas dropped significantly in FY 2021. This could partially reflect a consistency with reports that COVID-19 had a disproportionate impact on lower income individuals early in the pandemic. We have not been able to ascertain why the average income of this population would drop precipitously in FY 2021.

Figure 6. Mean Net Worth of SNF Residents From Zip Codes With A Higher Poverty Rate Decreased At Pandemic Onset and Returned to Baseline in FY 2021



5. AHCA Results Suggesting that the proposed "Control-Period-based Adjustment Factor" <u>is not adequate</u> to account for COVID "spillover" effects

We identified seventeen beneficiary characteristics, demographics, or social risk factors that demonstrated negative COVID *"spillover"* effects early in the PHE, and these trends that <u>did not</u> return to pre-PHE levels in FY 2021. These seventeen factors are:

- *Claim PDPM Component CMI Trends*
- *MDS Primary Diagnosis Clinical Profile*
- *MDS Respiratory Failure*
- *MDS Pressure Ulcers and Injuries*
- *MDS Delirium*
- *MDS Incontinence*
- *MDS Depression*
- *Claim Gender*
- *Claim Age*
- *Claim Race*
- *Claim ESRD Status*
- *Claim Medicare/Medicaid Dual Status*
- *Claim Disability Eligibility Status*
- *Claim Rural Area*
- *Claim Low English Proficiency Area*
- *MDS Marital Status*
- *MDS Need for Interpreter*

Based on our updated analysis summarized below for each of the seventeen factors, we continue to believe that there are COVID *"spillover"* effects that have yet to be sufficiently accounted for, particularly during the months of April and May 2021 where patients and healthcare personnel were still in the process of receiving the initial dose of the COVID-19 vaccine, and during the early phase of the Delta variant surge beginning in August and September 2021. **These remaining unaccounted for *"spillover"* effects justify our request for CMS to consider further refinement, including excluding data from other months in FY 2021 from the CMS parity adjustment analysis, specifically the months of April, May, August, and September.**

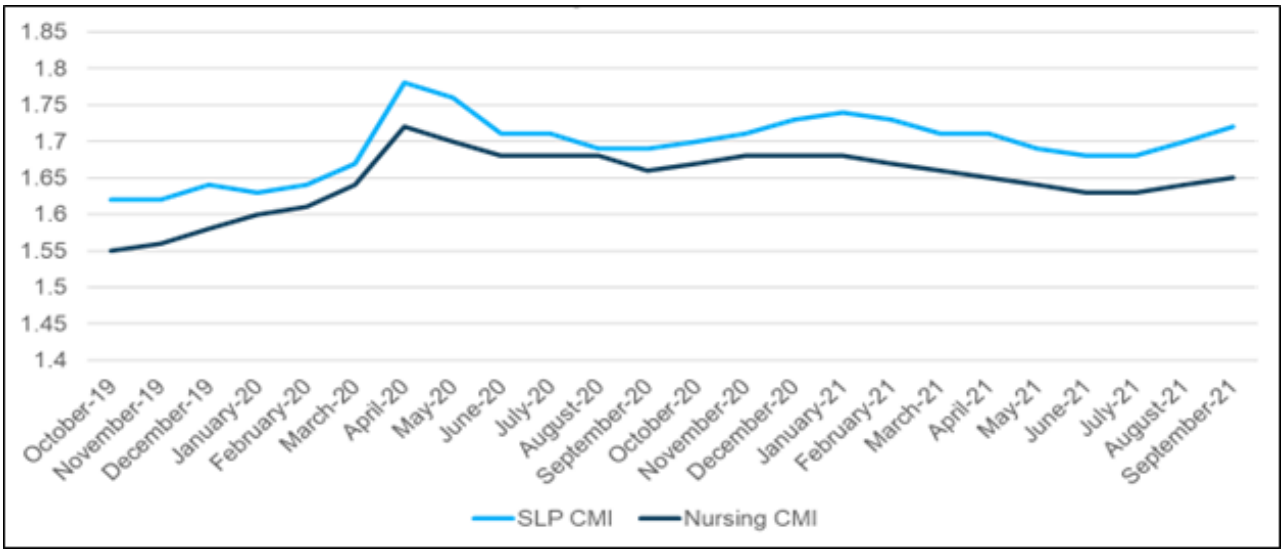
Below are comments specific to each of these factors:

Claim PDPM CMI Trends

The patients in this analysis were those admitted to SNFs via the traditional process of admission from a hospital following a 3-day qualifying inpatient stay. These were patients without COVID and without Section 1135 waiver use. As reflected in Figure 7, the onset of the Delta variant beginning in August and September 2021 immediately impacted the claim CMI's, particularly for the SLP (light blue line) and Nursing component (dark blue line), which spiked to levels higher than the pre-COVID months and are similar to the April 2020-March March 2021 high COVID months that CMS proposes to exclude from the parity adjustment analysis. Similarly, the claim CMIs during April-May 2021 were elevated above pre-PHE levels. During this period, which marked the latter stages of the winter 2020-2021 surge, providers were still in the process of getting patients and healthcare personnel vaccinated. For all practical purposes, the only months in FY 2021 where it appears the PDPM component CMIs were the most stable and resembled pre-pandemic levels, and where the *"spillover"* effect is nominal were July and August.

While we understand the rationale for CMS to attempt to include April, May, August, and September 2021 claims as a proxy for seasonal case-mix variations, we do not believe tht logic applies in this case because these are not traditionally months with seasonal increases in patient case-mix acuity. Therefore, the observed elevated CMIs are likely due to COVID *"spillover"* effects that require mitigation. **Removing these four months from the *"Control-Period-based Adjustment Factor"* approach would help address this challenge and could potentially reduce the parity adjustment amount by 0.1 to 0.2 percent.**

Figure 7. Claim PDPM Component CMI Trend With COVID Surges



MDS Primary Diagnosis Clinical Profile

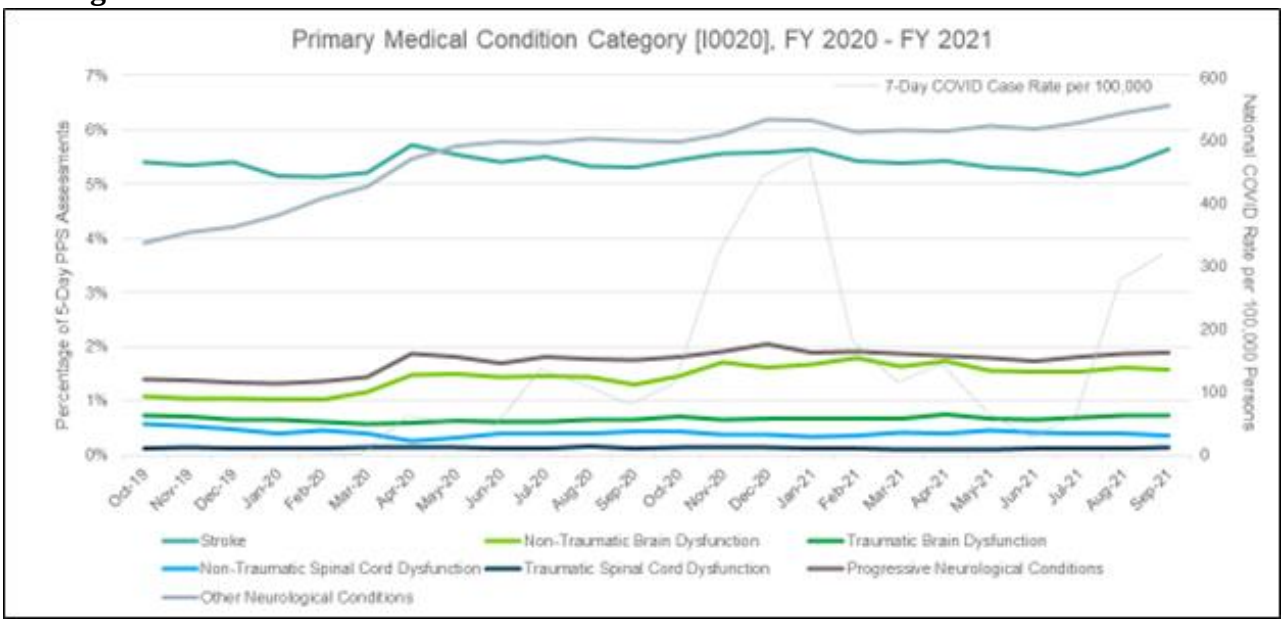
After removing Part A admissions with a COVID-19 diagnosis we evaluated the pattern of the thirteen primary medical conditions categories reported in MDS Item I0020 of the SNF PPS 5-day assessment.

When considering the observations and probable explanations of the primary medical condition category trends of non-COVID patient SNF PPS 5-day assessments through the PHE we believe that the proposed *"Control-Period-based Adjustment Factor"* methodology approach is a much-improved parity adjustment approach compared to the approach proposed in the FY 2022 SNF rulemaking. However, we also believe the currently proposed approach will not completely mitigate for the observed shift in the primary medical condition category for the SNF stay as identified in the SNF PPS MDS 5-Day assessment item I0020 because some of the shifts toward neurological conditions that disproportionally impact the SLP, Nursing, and NTA CMI values did not follow COVID surge patterns, and therefore reflect a higher patient acuity patient upon admission than was present pre-PHE, even in low COVID months.

As depicted in Figure 8, from the onset of the PHE there was a higher share of non-COVID Part A admissions reported with primary neurological conditions, particularly "other neurological conditions" (grey line) followed by "progressive neurological conditions" (lavender line) and "non-traumatic brain dysfunction" (light green line), and this elevated pattern has persisted throughout the PHE. Many of the underlying ICD-10 diagnoses that can elevate the PDPM SLP,

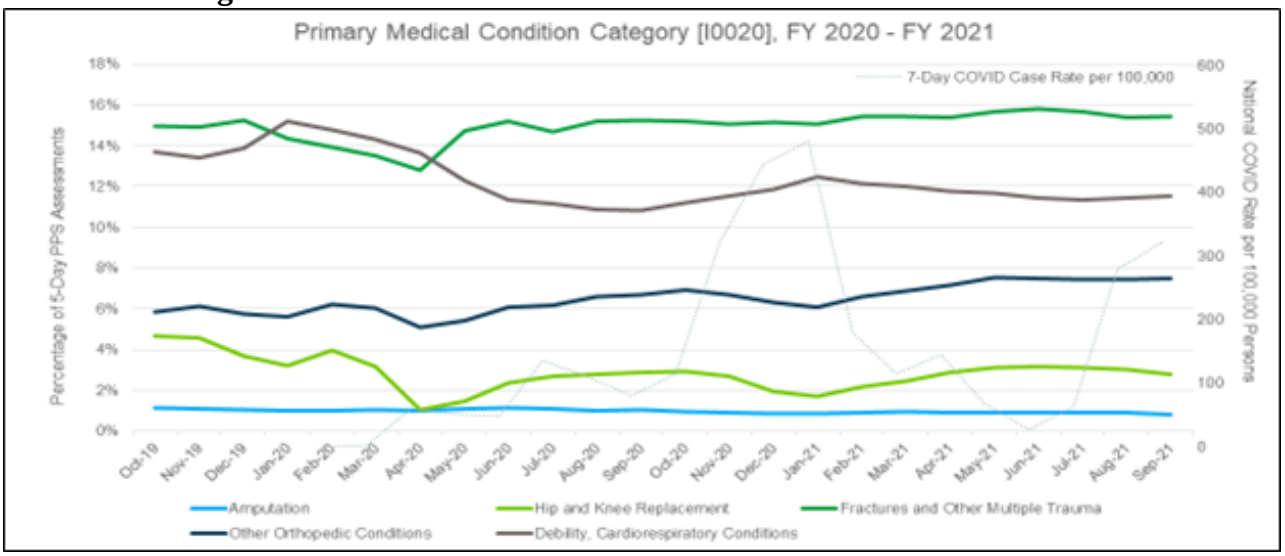
Nursing, and NTA component CMIs are related to neurological conditions. The fact that the share of these primary condition categories remains elevated is one indicator that the patient acuity profile of the proposed *"Control-Period-based Adjustment Factor"* is different than the pre-PHE profile and remains an unaccounted-for *"spillover"* effect.

Figure 8. Higher Share of Admissions Had a Neurological Primary Medical Condition Throughout the PHE



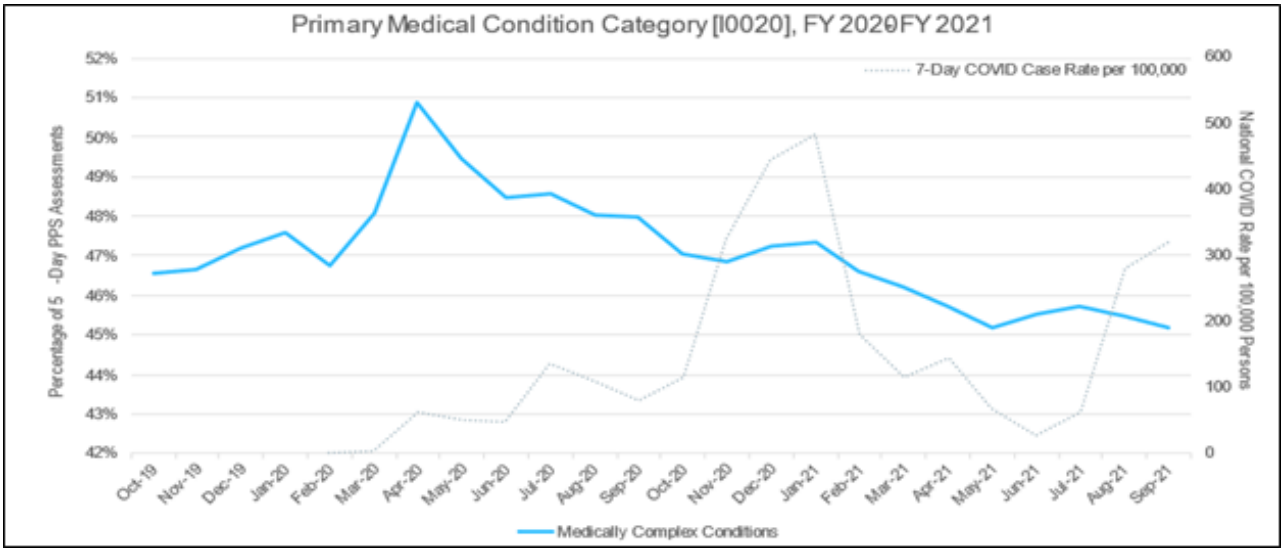
Along a similar vein, as depicted in Figure 9, from the onset of the PHE there was a lower share of non-COVID Part A admissions reported in MDS Item I0020 with primary orthopedic conditions observed during COVID surges that return to near baseline during low COVID months. In contrast, the share of non-COVID Part A admissions reported with primary debility and non-COVID-related cardiorespiratory conditions (grey line) dropped significantly with the onset of the PHE and remain depressed. Traditionally, debility and general cardiorespiratory conditions not requiring extensive services have been assigned to lower acuity CMGs. Given the dramatic drop in traditional qualifying hospital stay admissions of 3-days or more (Figure 1) and the growing consensus cited by MedPAC in their March 2022 Report To Congress that such lower acuity patients are instead being discharged to home, and that this hospital discharge pattern is likely to remain after the end of the PHE (see discussion in Section 3 of these parity adjustment comments), these trends again are an indicator that the patient acuity profile of the proposed *"Control-Period-based Adjustment Factor"* is different than the pre-PHE profile and remains an unaccounted-for *"spillover"* effect.

Figure 9. Lower Share of Admissions for Orthopedic Primary Medical Conditions Observed During COVID Surges While General Debility/Cardiorespiratory Conditions Declined Throughout the PHE



As depicted in Figure 10, the remaining primary medical condition reported in MDS Item I0020 non-COVID Part A admissions was for medically complex conditions (light blue line). Here, the share of medically complex conditions reported on the SNF PPS 5-day assessment spiked with the onset of the PHE then declined to below baseline through the end of the FY 2021 analysis period. We note that this pattern is like the Figure 2 HCC risk score trends of non-COVID/non-waiver SNF admissions. This suggests and provides some supporting evidence that in the early phases of the PHE, the patient profile shifted dramatically towards patients with multiple chronic conditions that also required a SNF level of care providing justification for the concept of the proposed *"Control-Period-based Adjustment Factor"*.

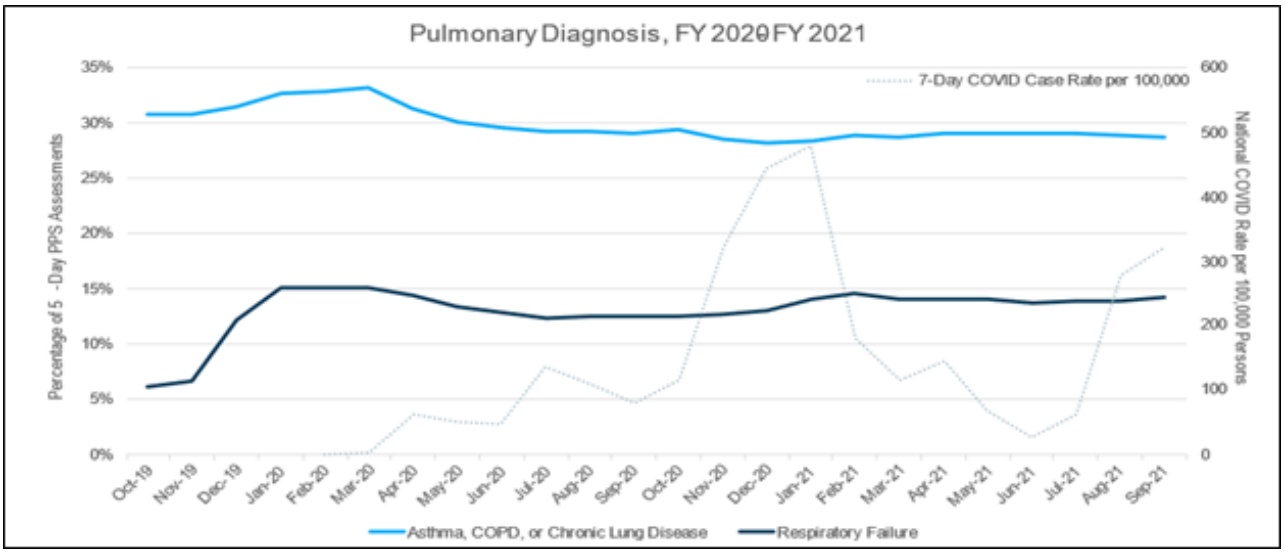
Figure 10. Share of Medically Complex Conditions Spiked as a Primary Medical Condition at Onset of PHE



MDS Respiratory Failure

Other SNF PPS 5-day MDS assessment item trends during the PHE in non-COVID Part A admissions such as item I6300 - Respiratory Failure conditions depicted in Figure 11 also spiked at the onset of the PHE and remained elevated throughout the PHE. Although these patients did not have COVID upon admission, their symptoms reflect high acuity needs, and if they require oxygen therapy, they are classified into one of the higher PDPM Nursing component Special Care Low CMG groups. Again, we believe the currently proposed parity adjustment approach will not completely mitigate for the observed shift in reported respiratory conditions of non-COVID patients did not follow COVID surge patterns, and therefore reflect a higher patient acuity patient upon admission than was present pre-PHE, even in low COVID months.

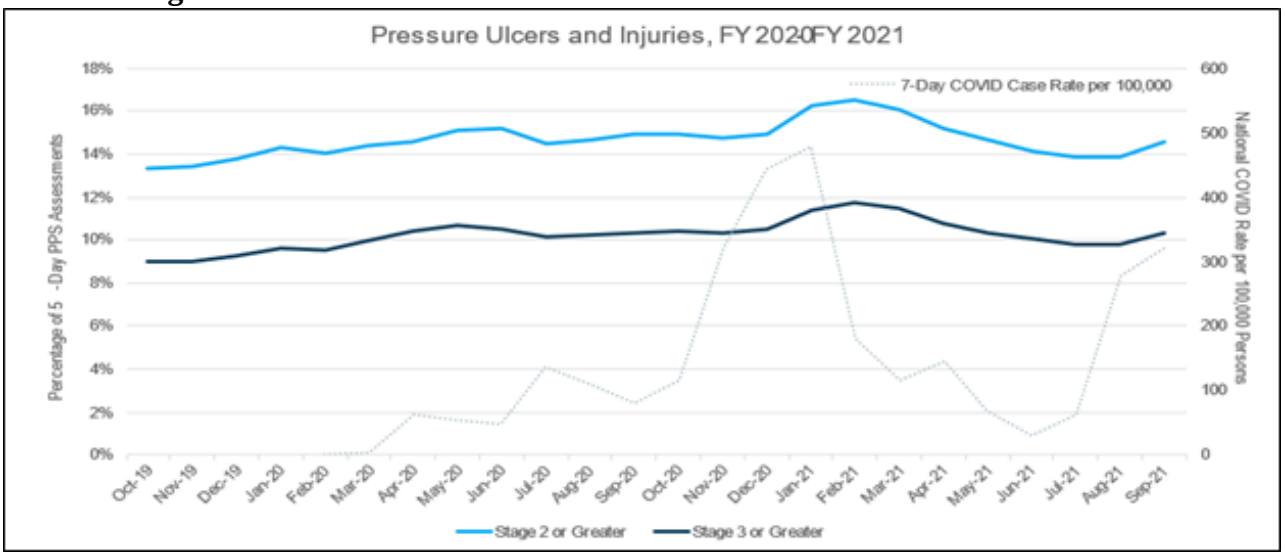
Figure 11. Share of Non-COVID Respiratory Failure Admissions Spiked Throughout the PHE



MDS Pressure Ulcers and Injuries

Like respiratory failure, SNF PPS 5-day MDS assessment item trends during the PHE in non-COVID Part A admissions related to pressure ulcers shifted (Figure 12). Specifically, the presence of Stage 2 Pressure Ulcers or greater (Items M0300B1-G1) and Stage 3 Pressure Ulcers or greater (Items M0300C1-G1) spiked during COVID surges and remained elevated even during low COVID months in FY 2021. Because these wounds were present upon the Part A Admission, they do not reflect wounds incurred during the Part A stay but do reflect higher acuity needs upon admission than was present pre-PHE. Since such wounds typically require specific time-intensive nursing treatments, these patients typically are classified into the higher acuity PDPM Nursing component Special Care Low CMG. In addition, Stage 4 pressure ulcers (Item M0300D1) are assigned one NTA component point which could elevate the CMG assigned for that component. Again, we believe the currently proposed parity adjustment approach will not completely mitigate for the observed shift in reported pressure ulcer conditions of non-COVID patients that were elevated throughout the PHE, including low COVID months.

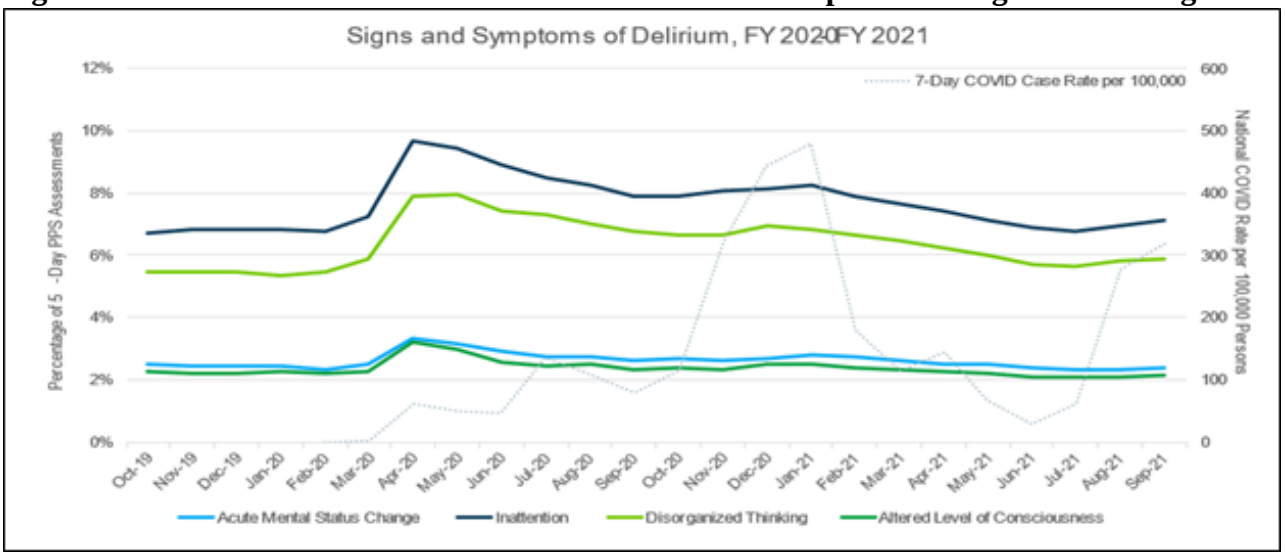
Figure 12. The Percent of Patients with Pressure Ulcers on Admission Spiked During COVID Surges and Remained Elevated Above Pre-PHE Levels



MDS Delirium

While the presence of delirium upon admission and the related SNF PPS 5-day MDS assessment items C1301A-D do not impact PDPM CMGs, we believed it was important to explore this factor as an indicator of a clinical complexity shift that may have occurred during the PHE. As depicted in Figure 13, the percent of patients with signs of delirium for non-COVID Part A admissions spiked during COVID surges for all four items, particularly for the inattention and disorganized thinking signs, and these trends remained elevated above the pre-PPE baseline throughout FY 2021.

Figure 13. Percent of Patients with Delirium on Admission Spiked During COVID Surges



MDS Depression

In the proposed rule CMS comments that the Agency's data shows that the MDS depression scores had already exhibited clear changes concurrent with PDPM implementation and well before the start of the COVID–19 PHE. Moderate to severe depression is indicated by a score of greater than or equal to 10 but not 99 in MDS item D0300 - Resident Mood Interview (PHQ-9©) Total Severity Score, or a score of greater than or equal to 10 in MDS item D0600 – Staff Assessment of Resident Mood (PHQ-9-OV©) Total Severity Score.

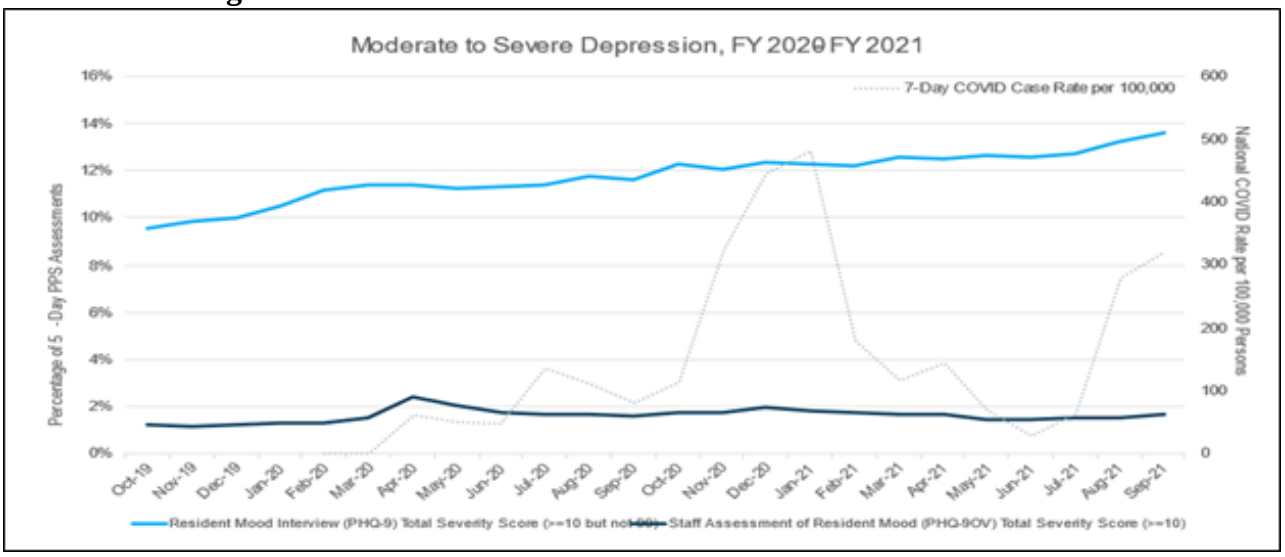
CMS notes that in the year prior to PDPM implementation (FY 2019) an average of 4 percent of SNF Part A patients were identified as having depression. However, in the three months directly following PDPM implementation and before the start of the COVID–19 PHE (October 2019 to December 2019), these averages for depression increased to 11 percent of stays (87 FR 22740).

As depicted in Figure 14, AHCA acknowledges that, as CMS indicated, there was an increase in the reported rates of moderate to severe depression on the SNF PPS 5-day assessment upon the implementation of PDPM. However, Figure 14 also demonstrates that the proportion of patients entering a SNF with depression increased further during the PHE to nearly 14 percent, but unlike other patient characteristics trends during the pandemic that typically ebbed and flowed during COVID surges, the percentage of beneficiaries being admitted to SNFs with depression continued to increase steadily through the end of FY 2021, even after most patients and healthcare personnel were vaccinated.

AHCA believes that this trend is the result of the confluence of numerous factors including the limitations regarding visitation and other infection control protocols due to the PHE, and the high mortality rate prior to the vaccine rollout that led to higher levels of mood distress of beneficiaries being admitted for Part A stays early in the PHE. We also believe that the rates for depression continued to rise in FY 2022 despite lower mortality rates after the vaccine rollout is due to lingering sociological and psychological negative stigma placed on the SNF provider setting in the press and from political leaders. Such negative stigma has made many beneficiaries fearful of SNFs, and as the PHE has persisted, people being admitted to a SNF are entering with much less hope and a much more negative outlook of their chances of returning home at a rate higher than what would have occurred had it not been for the COVID-19 pandemic.

Whether such coding changes reflect more accurate coding will ultimately be determined through Medicare audits. However, given that recent CMS Chronic Conditions Warehouse SNF provider public use files for 2019 indicates that 54 percent of SNF Medicare admissions have a history of depression[4], the increased reporting of depression may reflect improvements in assessment that can translate to improved care planning related to the mood disorder. In total, we believe the currently proposed parity adjustment approach will not completely mitigate the observed shift in reported patient depression of non-COVID patients that were elevated throughout the PHE, including low COVID months

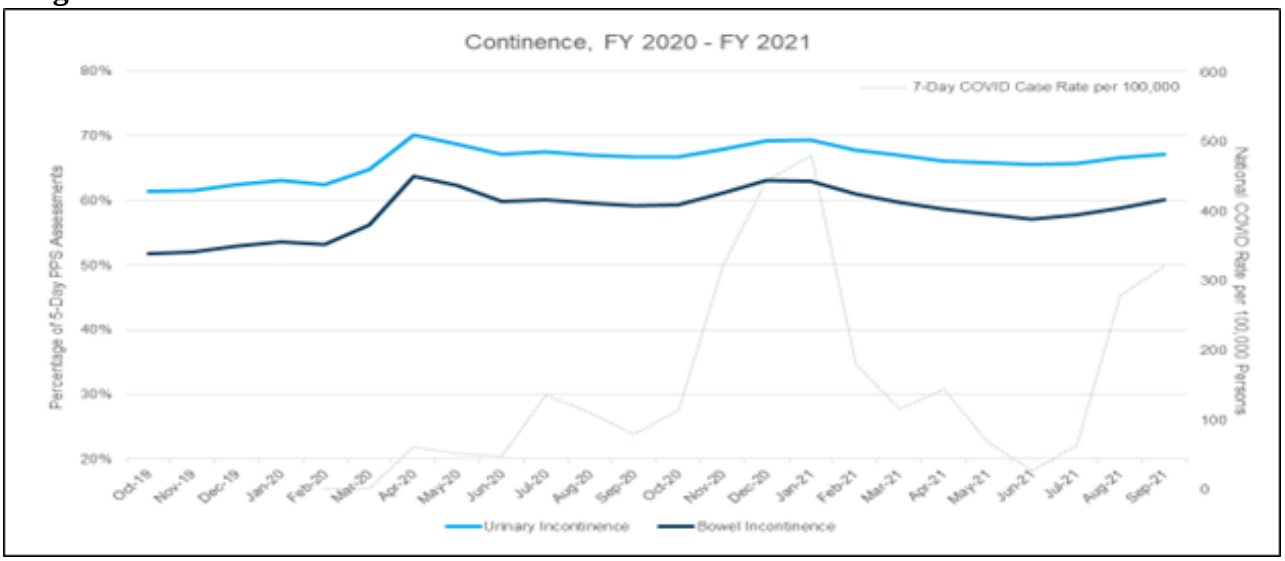
Figure 14. Percent of Patients with Moderate to Severe Depression Admissions Steadily Increased During the PHE



MDS Incontinence

Bladder and bowel incontinence upon admission and the related SNF PPS 5-day MDS assessment items (H0300 and H0400) also do not impact PDPM CMGs, but we believed it was important to explore these factors as indicators of a clinical complexity shift that may have occurred during the PHE. As depicted in Figure 15, the percent of patients with both urinary (light blue line) and bowel incontinence (dark blue line) for non-COVID Part A admissions spiked during COVID surges and these trends remained elevated above the pre-PPE baseline throughout FY 2021.

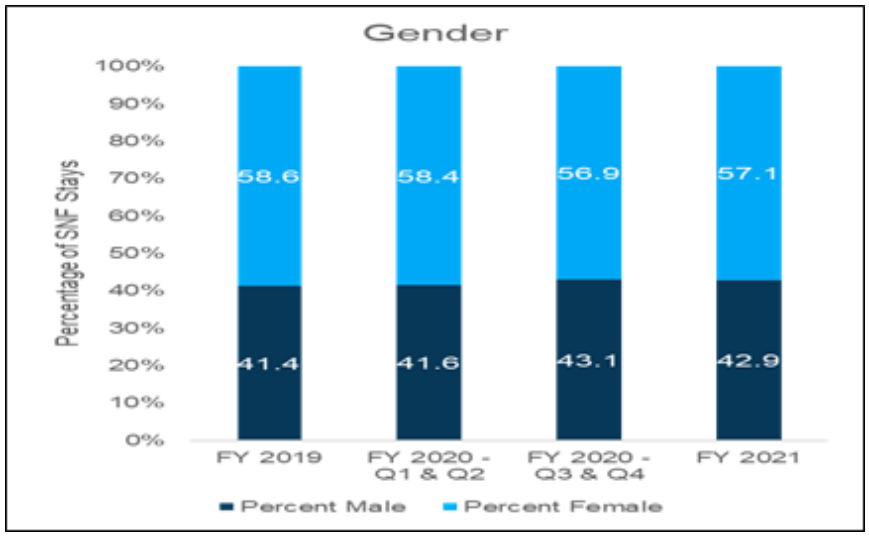
Figure 15. Percent of Patients With Incontinence on Admission Spiked During COVID Surges and Remained Above Pre-Pandemic Levels



Claim Gender

As depicted in the Figure 16 claims analysis, after removing SNF stays with a COVID-19 diagnosis and SNF stays admitted through the Section 1135 waiver, there was a jump in the proportion of males (dark blue portion of bars) for beneficiary stays at the start of the COVID-19 pandemic and remained above pre-PHE levels in FY 2021. There could be a number of factors contributing to this gender shift during the PHE, ranging from pre-COVID comorbidity differences between the genders to challenges with obtaining support in the home due to a spousal illness, or inability for family, home health or other community support due to COVID-19 infection control restrictions. We believe that the proposed *"Control-Period-based Adjustment Factor"* methodology may not effectively mitigate for such beneficiary gender impacts since the observed male gender proportion spike remains elevated at a lower level through FY 2021.

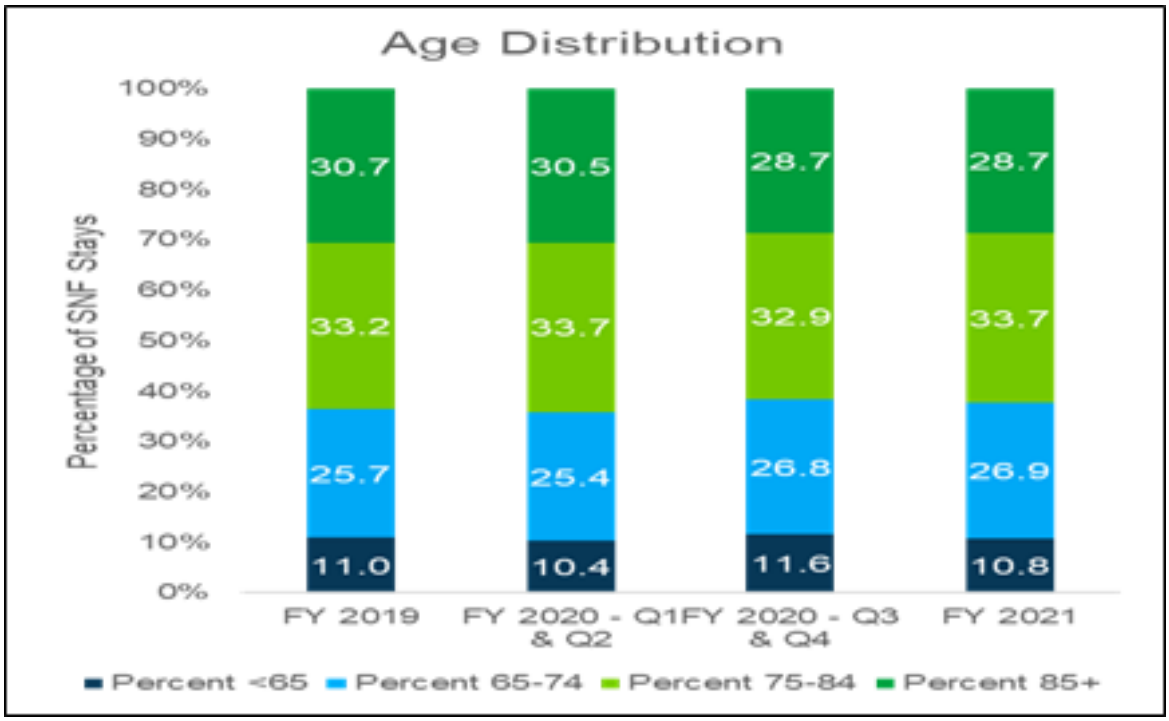
Figure 16. Percent Male Admissions Increased With the Onset of COVID and Trended Towards Baseline in FY 2021



Claim Age

As depicted in the Figure 17 claims analysis, after removing SNF stays with a COVID-19 diagnosis and SNF stays admitted through the waiver, there was a jump in the proportion under 65 and from 65-74 years old beneficiary stays at the start of the COVID-19 pandemic. However, while the proportion of the under 65 age group (dark blue portion of bars) returned to pre-PHE levels in FY 2021, the proportion of the 65-74 age group (light blue portion of bars) remained elevated. There could be several factors contributing to this age demographic shift, but the major contributing factor is the higher COVID-19 mortality rate for beneficiaries over 75 which decreased the proportion of the Medicare population potentially eligible for post-inpatient hospital SNF services. We believe that the proposed *"Control-Period-based Adjustment Factor"* methodology mitigates for some of the age impacts since the months of the most significant observed age group distribution shifts are excluded from the parity adjustment analysis. However, the lingering elevation in the proportion of 65-74 year old beneficiaries could be the result of some unresolved COVID *"spillover"* effects.

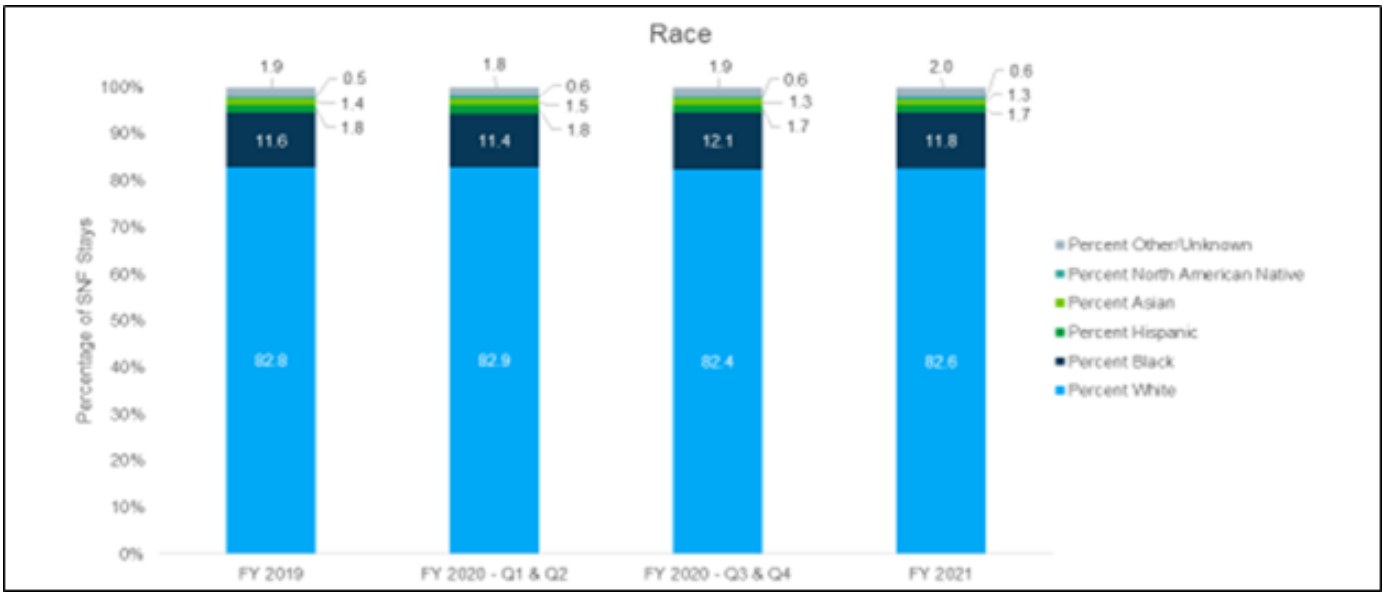
Figure 17. Percent Under 65 and 65-74 Year Old Admissions Increased With the Onset of COVID and 65-74 Remained Elevated in FY 2021



Claim Race

With regards to the beneficiary's race, As depicted in the Figure 18 claims analysis, after removing SNF stays with a COVID-19 diagnosis and SNF stays admitted through the waiver, there was a jump in the proportion black beneficiaries (dark blue portion of bars) at the start of the COVID-19 pandemic. The proportion of black beneficiaries reduced slightly in 2021 but remained elevated above pre-PHE levels. Given the fact that the black Medicare population on the average has traditionally presented with increased levels of chronic conditions and elevated social risk factors we believe that the proposed *"Control-Period-based Adjustment Factor"* methodology may not mitigate sufficiently for race impacts. While the proposed parity adjustment approach excludes the months of the most significant observed distribution shifts by race, the lingering elevation in the proportion of black beneficiaries could be the result of some unresolved COVID *"spillover"* effects.

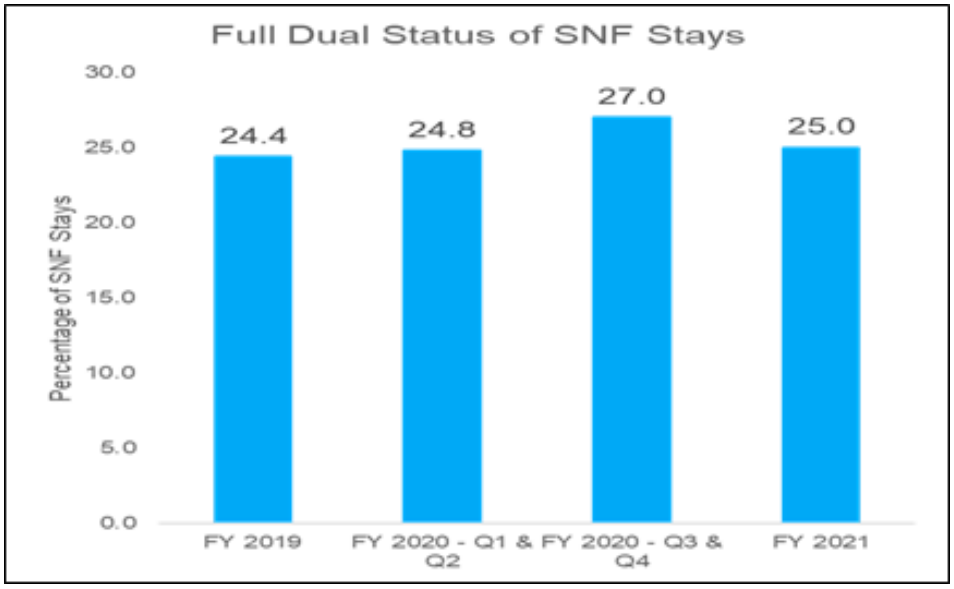
Figure 18. Percent of Black Patient Admissions Increased With the Onset of COVID and Remained Elevated in FY 2021



Claim Medicare/Medicaid Dual Status

With regards to the beneficiary's status as both a Medicare and Medicaid recipient (dual status), as depicted in the Figure 19 claims analysis, after removing SNF stays with a COVID-19 diagnosis and SNF stays admitted through the waiver, there was a jump in the proportion dual-eligible beneficiaries at the start of the COVID-19 pandemic. The proportion of dual eligible beneficiaries reduced slightly in 2021 but remained elevated above pre-PHE levels. Given the fact that the dual eligible population on the average has traditionally presented with increased levels of chronic conditions and elevated social risk factors we believe that the proposed *"Control-Period-based Adjustment Factor"* methodology may not mitigate sufficiently for dual eligible impacts. Although the proposed parity adjustment approach excludes the months of the most significant observed distribution shifts by dual eligibility, the lingering elevation in the proportion of dual eligible beneficiaries could be the result of some unresolved COVID *"spillover"* effects.

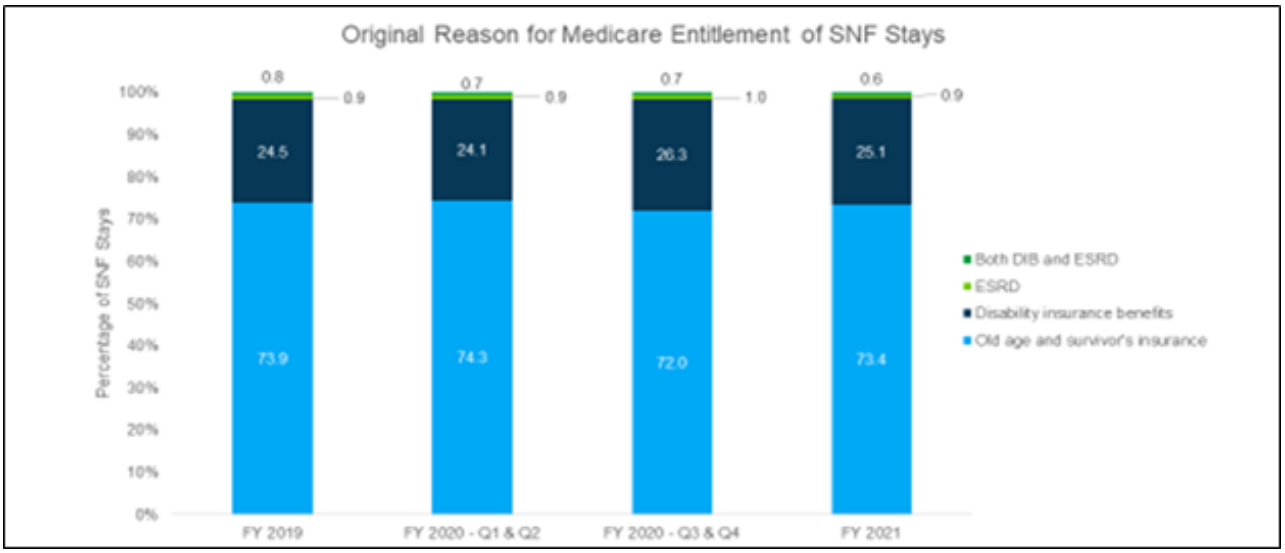
Figure 19. Percent of Dual Status Admissions Increased With the Onset of COVID and Remained Elevated in FY 2021



Claim Disability Eligibility Status

With regards to the beneficiary's Medicare disability eligibility status (under 65 and fully disabled), as depicted in the Figure 20 claims analysis, after removing SNF stays with a COVID-19 diagnosis and SNF stays admitted through the waiver, there was a jump in the proportion disability eligibility status beneficiaries at the start of the COVID-19 pandemic (dark blue portion of bars). The proportion of disability status eligible beneficiaries reduced slightly in 2021 but remained elevated above pre-PHE levels. Given the fact that the disability status population on the average has traditionally presented with increased levels of chronic conditions and elevated social risk factors we believe that the proposed *"Control-Period-based Adjustment Factor"* methodology may not mitigate sufficiently for disability status impacts. Although the proposed parity adjustment approach excludes the months of the most significant observed distribution shifts by disability status eligibility, the lingering elevation in the proportion of disability status eligible beneficiaries could be the result of some unresolved COVID *"spillover"* effects.

Figure 20. Percent of Admissions for Disability Eligibility Patients Increased with the Onset of COVID and Remained Elevated in FY 2021

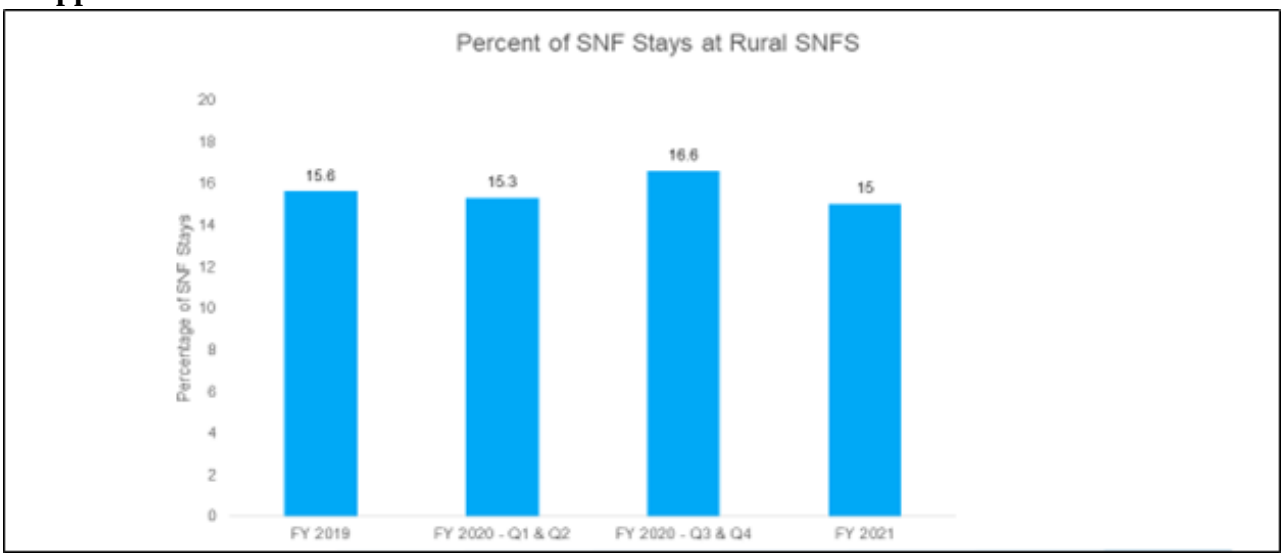


Claim Rural Area

With regards to the beneficiary's geographic location (urban versus rural provider admission), as depicted in the Figure 21 claims analysis, after removing SNF stays with a COVID-19 diagnosis and SNF stays admitted through the waiver, there was a jump in the proportion beneficiaries in rural locations at the start of the COVID-19 pandemic. The proportion of beneficiaries admitted to rural providers in 2021 dropped below pre-PHE levels. We suspect that the proportion of traditional 3 or more-day inpatient hospital stay admissions to rural providers increased early in the pandemic is because rural locations have a lower concentration of community-based health care and residential supports. Many beneficiaries in rural locations requiring post-acute services were able to obtain necessary services when residing in a SNF rather than at home.

We also believe the significant drop in the proportion of traditional post-acute SNF stays in rural locations in FY 2021 reflects increased beneficiary access problems as more and more rural SNFs shuttered their doors and closed in FY 2021. In these situations, beneficiaries that already have challenges with obtaining necessary community support services now needed to travel 50 miles or more to obtain necessary SNF services. We do not believe the proposed *"Control-Period-based Adjustment Factor"* methodology parity adjustment approach will make a significant impact on this structural beneficiary access problem, but any reduction from the currently proposed 4.6 percent adjustment based on other unresolved beneficiary characteristics COVID *"spillover"* effects described in our comments may help prevent some additional rural SNF provider closures.

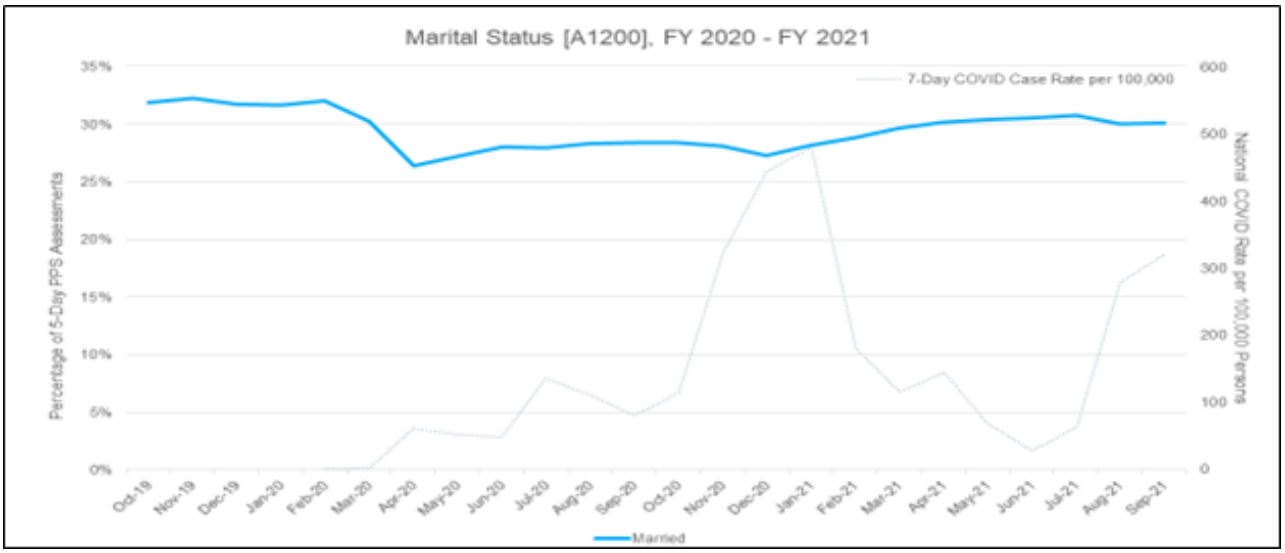
Figure 21. Share of Admissions in Rural SNFs Increased with the Onset of COVID then Dropped Below Pre-PHE Levels in FY 2021



MDS Marital Status

While marital status is not a beneficiary characteristic impacting PDPM CMIs, it is a social determinant of health patient supports characteristic that could impact whether a person is admitted to a SNF versus being discharged from a hospital to home for post-acute services. As depicted in Figure 22, the SNF PPS 5-day MDS assessment item trends during the PHE in non-COVID Part A admissions for Item A1200 – Marital Status (light blue line) demonstrates a significant drop in married beneficiaries early in the PHE and other drops during COVID surges. Overall, the proportion of married Medicare Part A patients did not return to baseline throughout FY 2021. Although these patients did not have COVID upon admission, this could suggest that were it not for the pandemic, the proportion of married individuals admitted to a SNF would have been higher than observed. We believe the currently proposed parity adjustment approach will not completely mitigate for the observed shift in beneficiary marriage status non-COVID patients, and therefore reflect COVID impacts on beneficiary social supports upon admission that is different than pre-PHE, even in low COVID months.

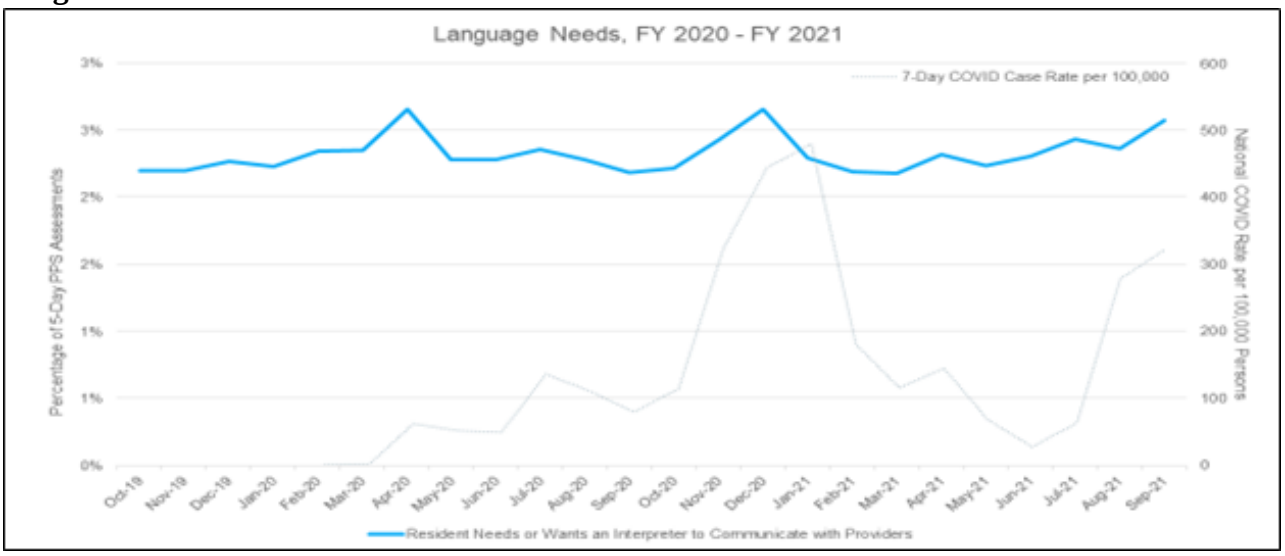
Figure 22. Percent of Married Patient Admissions Dropped During COVID Surges and Remained Below Pre-PHE Levels



MDS Need for Interpreter

When we evaluated the distribution of Part A stays initiated for beneficiaries who requested interpreter services (Item A1100A) there was a jump in the proportion patients from these areas for beneficiary stays during COVID spikes with levels returning near baseline during periods with low COVID incidence (Figure 23 light blue line). We believe that although the proposed *"Control-Period-based Adjustment Factor"* methodology mitigates for most of the impacts associated with the need for interpreter services during the early COVID surges, the proposed approach does not mitigate for the spike observed during the early months of the Delta variant surge in August and September 2021.

Figure 23. Percent of Patients Requesting Interpreter Services Spiked During COVID Surges



6. AHCA Recommendations Related to PDPM Parity Adjustment Amount

From our analysis of claims, MDS assessments, and other available public data sets described above, we observed changes in the characteristics of SNF patients upon admission during the pandemic. Additionally, we identified several demographic and social determinants of health patient characteristics that shifted during 2020 and 2021 that suggest the traditional SNF admission population is different than the pre-COVID era, and that the COVID-19 pandemic had a disproportionate impact on patients with higher complexity and those representing traditionally underserved populations. While some changes returned to or neared pre-pandemic levels by September 2021, many did not. Such changes contributed to month-to-month average changes in PDPM component CMIs for non-COVID/non-waiver patients suggesting *"spillover"* effects. As a result of this analysis, AHCA believes that CMS needs to further refine the proposed *"Control-Period-based Adjustment Factor"* methodology by adding April, May, August, and September 2021 to the months excluded from the PDPM parity adjustment calculations.

Our specific recommendation related to the PDPM parity adjustment amount is:

- **To mitigate for COVID *"spillover"* effects that remain despite the improvements included in the proposed CMS *"Control-Period-based Adjustment Factor"* parity adjustment approach, we recommend that CMS further evaluate the data to also exclude the months of April, May, August, and September 2021 from the parity adjustment calculations.**
    - **We believe this approach will mitigate most to the remaining *"spillover"* effects and will result in an additional 0.1 to 0.2 percent reduction below the currently proposed 4.6 percent parity adjustment amount.**

7. AHCA Recommendations About Whether the Adjustment Should be Applied Equally Across all Components

AHCA appreciates that CMS responded to requests to examine the feasibility and impacts of potentially applying any finalized parity adjustment amount across all five PDPM case-mix adjusted components (PT, OT, SLP, Nursing, and NTA), or to target the parity adjustment to those components that demonstrated CMG distributions different than expected, and which resulted in higher CMIs than expected. After reviewing the CMS analysis and rationale, we agree that, in the absence of re-designing the PDPM payment model from the ground-up based on observed PDPM CMI's, the adoption of an even distribution for the parity adjustment would best maintain the stability of the PDPM payment model. In particular, we believe that while the PDPM design underestimated the real-world SLP, Nursing, and NTA case-mix distribution patterns, we believe it would be destabilizing for the PDPM payment model to target the parity adjustment to take resources away from those components which would shift the relative component payment amounts. An equal across the board parity adjustment would maintain the relative component payment amounts consistent with actual observed PDPM case-mix distributions.

Our specific recommendation related to how to apply the PDPM parity adjustment across components question is:

- **AHCA recommends that CMS adopt, as proposed, to apply the final recalibrated parity adjustment across all PDPM CMIs in equal measure.**
-

8. AHCA Recommendations Related to Delay or Phase-In of Parity Adjustment Amount

Due to the currently highly unstable state of the sector discussed extensively in Section I of this comment letter, we strongly oppose a one-time parity adjustment being applied in FY 2023. AHCA believes the proposed one-time parity adjustment on FY 2023 will exacerbate staffing shortages and cause serious harm to beneficiary access to quality care. While providers would prefer no parity adjustment at all, AHCA recognizes that CMS intended for the implementation of PDPM to be budget neutral, and that the Agency had responded to stakeholder comments to date on ways to assure that any parity adjustment amount does not reflect an inappropriate overcorrection. However, continued delays in implementation also delay predictability for the sector, which is also undesirable.

Balancing all these factors, we believe the most appropriate approach would be to lock in the parity adjustment percentage amount and then apply a phase-in approach. Additionally, the phase-in should be evenly distributed in one-third increments across three years. Such an approach would make it likely that providers would not experience a negative net market basket annual update during the phase-in period, which would provide much more stability to the sector than the proposed 0.6 percent FY 2023 negative adjustment of $320 million.

Our specific recommendation related to the PDPM parity adjustment delay or phase in question is:

- **To assure some predictability and stability to the sector, AHCA recommends that CMS should lock in the parity adjustment amount this year after considering public comments regarding the appropriate percentage methodology, and then phase in the reduction evenly over 3 years (e.g., 1.5 percent per year).**
    - **Due to the state of the sector, we strongly oppose a one-time parity adjustment being applied in FY 2023. AHCA believes the proposed one-time parity adjustment on FY 2023 will exacerbate staffing shortages and cause serious harm to beneficiary access to quality care.**

[1] Medicare Payment Advisory Commission (MedPAC) Report to Congress, Chapter 7, Skilled nursing facility services, March 2022.

[2] Brown, D. 2021. A new normal: Experts don't see discharges to SNFs returning to former levels. McKnight's Long Term Care News, April 15.

[3] Werner,RM, and Bressman,E. Trends in Post-Acute Care Utilization During the COVID-19 Pandemic. JAMDA 22 (2021) 2496-2499. https://doi.org/10.1016/j.jamda.2021.09.001

[4] Skilled Nursing Facility by Provider and Service Table 2019. Data.CMS.Gov webpage.

Section V. Infection Control Request for Information

CMS has requested public comment about isolation due to active infection and how the PHE has affected the relative staff time resources necessary for treating these patients. Specifically, CMS invited comments on whether the relative increase in resource utilization for each of the patients within a cohorted room, all with an active infection, is the same or comparable to that of the relative increase in resource utilization associated with a patient that is single-occupancy isolation due to an active infection.

AHCA Overall Position:

- **AHCA requests a revision of the MDS isolation definition that would permit coding of patients with an active infection within a cohorted room isolation during a public health emergency or other local situations, when provided in a manner consistent with public health guidance at the time.**
- **AHCA requests a revision of the PDPM patient classification methodology of the Nursing and NTA components to classify patients with an active infection within a cohorted room isolation during a public health emergency or other local situations into a classification group appropriate for the resources necessary to treat patients with an active and highly transmissible infection.**

Discussion:

AHCA appreciates the opportunity to provide comment regarding this RFI. We believe this issue is extremely important as is related to the question of whether the Payment Driven Payment Model (PDPM) accounts for patient care needs associated with an active infectious disease requiring quarantine when following guidance provided by CMS and public health officials. We strongly believe that the current CMS isolation coding and PDPM payment policies are inadequate to address patient care needs during the current COVID-19 public health emergency (PHE) and would continue to remain inadequate to address patient needs in future outbreaks of *"highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission."*

Below we discuss our rationale and recommended potential solutions for CMS to Consider adopting.

1. ***Current MDS Coding Requirements for item O0100M - Isolation for Active Infectious Disease***

AHCA Position:

- **AHCA is requesting that CMS consider revising criteria 3 of the MDS guidance that currently requires that the resident can only be in single-occupancy room isolation to meeting the criteria for MDS isolation item O0100M2.**
- **Specifically, AHCA suggests that CMS create a new MDS sub-item row indicating cohorted isolation. We envision the MDS guidance will limit the use of this code use to occur only during a declared national or regional PHE or other local situations, and only in situations where there are no available rooms that could accommodate single-occupancy isolation.**

As CMS has articulated in the RFI request, for a patient to currently qualify to be coded as being isolated for an active infectious disease, the patient must meet all following criteria listed in the Minimum Data Set Resident Assessment Instrument (MDS-RAI) manual[1]:

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

The MDS manual also states that the isolation item O0100M should not be coded if the resident:

1. Only has a history of infectious disease and is not symptomatic
2. If the precautions are standard precautions, because these types of precautions apply to everyone
3. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections

Furthermore, the MDS manual refers providers to the Centers for Disease Control and Prevention website for the most currently applicable isolation precautions guidelines.

We agree that the preferred standard of care in ordinary circumstances is for such patients with an active infection of a highly transmissible disease would be single-occupancy room isolation. However, we believe that during a declared public health emergency or other local situation, when government officials are compelled to issue guidance to providers to cohort active infectious patients into multiple occupancy rooms when there are no single-occupancy isolation

rooms available, it is essential for providers to be able to code the MDS to accurately reflect the patient's condition and care needs when such cohorted isolation level of care is necessary and furnished.

We anticipate that CMS would consult with stakeholders via technical expert panels (TEPs), notice and rulemaking, and other mechanisms to define what would constitute a *"local situation"*. However, we envision a local non-PHE situation could occur in cases such as 1) where there is a facility outbreak and residents cannot be relocated to another facility, and 2) where there is a facility fire, closure, or other isolated event where patients need to relocate to a facility that does not have the capacity for single-room isolation. While uncommon, such situations when they occur place tremendous stress on the facility and inflexible isolation coding and payment policies should not add to that stress.

By permitting MDS coding to describe cohorted isolation use during a PHE or other local situation, government officials would have a better understanding of the local impact and severity of such pathogens in geographic localities as the isolation code is the only indicator on the MDS that the patient has an active infection of a highly transmissible pathogen currently requiring an isolation level of care. Public health data analysis of single-occupancy vs cohorted occupancy patients would be helpful to better understand local impacts of the disease as well as help prepare for future outbreaks such as expanding single-occupancy capacity.

From the provider standpoint, by permitting MDS coding to describe cohorted isolation use during a PHE or local situations, providers could be eligible for more appropriate reimbursement for such patients to address the increased complexity in care needs if there is also a concurrent modification to the PDPM nursing and NTA component classification methodologies.

2. *CDC Determines Which Diagnoses Codes Meet the Criteria to be Coded as an Active Infectious Disease used in MDS item O0100M2*

AHCA Position:

- **AHCA recommends that the MDS coding guidance for item O0100M provide additional clarity that providers should refer to the most current the CDC ICD-10 coding guidance for active infectious disease, particularly with novel and highly infectious disease.**

SNF provider coding of an active infectious disease that could qualify to be coded into MDS item O0100M2 is not an arbitrary decision by SNF personnel. The MDS coding guidance directs providers to CDC guidelines related to preventing transmission of infectious agents in healthcare settings[2] detailing which conditions require an "isolation" level of care including elevated "transmission-based precautions". Additionally, it is the physician or non-physician practitioner and not SNF personnel that are responsible for establishing the ICD-10 diagnosis that would

qualify as an active infectious disease. **Such auditable diagnosis requirements provide a guardrail against inappropriate provider coding practices.**

AHCA notes that during the COVID-19 pandemic the CDC has issued very specific ICD-10 coding guidance to describe an active COVID-19 infection that could meet criteria 1 of the MDS coding guidance for the O01100M Isolation item, and that this guidance has evolved over time as more was learned about the virus.

2/20/2020-3/31/2020

Early in the COVID-19 PHE, the CDC issued a supplement to the ICD-10-CM Official Coding Guidelines to provide official diagnosis coding guidance for health care encounters and deaths related to the 2019 novel coronavirus (COVID-19) previously named 2019-nCoV until a new code associated with this novel virus could be established[3]. In summary, the general guidance directed providers to include codes for related conditions such as pneumonia (J12.89), acute bronchitis (J20.8 or J40), lower respiratory infection (J22 or J98.8), or acute respiratory distress syndrome (J80), and each of these codes would also be accompanied by code B97.29 denoting "Other coronavirus as the cause of diseases classified elsewhere". Providers could only code B97.29 if COVID-19 were confirmed by testing. **In other words, during this period, the patient would need to have both COVID symptoms and a positive COVID test to meet the active infection criteria of the MDS isolation item O0100M.**

Providers could not code B97.29 for exposure to COVID-19 (Z03.818 or Z20.828) could be used in these cases but they would not be considered as having the active infection criteria of the MDS isolation item O0100M. Other codes associated with signs and symptoms associated with COVID-19 and the provider documents it is "suspected", "possible" or "probable" COVID-19 such as cough (R05), shortness of breath (R06.2, fever, (R50.9 or Z20.828) also could not be assigned code B97.29 if not confirmed by testing. Additionally, the guidance indicated that Diagnosis code B34.2, Coronavirus infection, unspecified, would in generally not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be "unspecified."

4/1/2020-9/30/2020

Effective April 1, 2020, the CDC introduced ICD-10-CM code U07.1 to be used for confirmed cased of COVID-19 and updated their coding guidance[4]. For the most part, this new guidance was identical to the prior guidance and just substituted the new U07.1 code for the temporary B97.29 code, with the addition of the following guidance:

- Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. Presumptive positive COVID-19 test results should be coded as confirmed. A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC). CDC confirmation of local and state tests for COVID-19 is no longer required.

- For asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code Z11.59, Encounter for screening for other viral diseases.
- For asymptomatic individuals who test positive for COVID-19, assign code U07.1, COVID-19. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

This updated coding guidance further clarifies that the presence of the U07.1 diagnosis code can only be used for patients with COVID-19 confirmed or presumed confirmed to have an active infection by testing, whether symptomatic or not, thereby meeting the active infection criteria of the MDS isolation item O0100M. In contrast, asymptomatic individuals who are untested or without a confirmed or presumed confirmed test result would not meet the active infection criteria of the MDS isolation item O0100M.

10/1/2020-9/30/2022

For fiscal year 2021 the COVID-19 ICD-10 coding guidance was incorporated into the comprehensive annual ICD-10-CM Official Guidelines for Coding and Reporting guidance without substantive changes[5]. For fiscal year 2022 the annual ICD-10-CM Official Guidelines for Coding and Reporting guidance was updated to include a new code U09.9[6]. This new code was developed to define sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code U09.9, Post COVID-19 condition, unspecified. Code U09.9 should not be assigned for manifestations of an active (current) COVID-19 infection. If a patient has a condition(s) associated with a previous COVID-19 infection and develops a new active (current) COVID-19 infection, code U09.9 may be assigned in conjunction with code U07.1, COVID-19, to identify that the patient also has a condition(s) associated with a previous COVID-19 infection. **In other words, the new code U09.9 alone would not meet criteria 1 of the MDS isolation item O0100M, unless a new occurrence confirmed by testing was confirmed justifying the use of the U07.1 code.**

3. Clinical Care Needs of a Patient with an Active COVID-19 Infection

AHCA Position:

- **AHCA believes that there is no clinical difference between a patient with an active COVID-19 infection residing in single-room isolation and one cohorted with another similar active COVID-19 patient residing in the same multiple occupancy room.**
- **AHCA recommends that during the COVID-19 PHE and with any future PHE or other local situations involving highly transmissible or epidemiologically significant pathogens, the MDS patient assessment instrument and PDPM payment model must be modified to recognize the unique increased clinical care needs of patients with active infections that need to be isolated in cohorted multiple-occupancy rooms in**

compliance with government public health guidance in cases where insufficient single-occupancy isolation rooms are not available.

Patients with confirmed and highly contagious COVID-19 infections require significantly elevated levels of ongoing nurse assessment and patient-specific care. To offer more detail on additional nursing duties associated with COVID patient care, AHCA interviewed several clinicians. In Table 1 we provide an overview of those additional nursing patient assessment and COVID-19 specific care delivery duties performed above and beyond baseline pandemic-related infection control procedures otherwise performed on all residents during the PHE.

For clarity, we break down the additional clinical activities by COVID patient status consistent with current ICD-10 coding and isolation guidance that meet criteria 1 of the MDS isolation item O0100M:

1. COVID-Positive, Symptomatic; and
2. COVID-Positive, Asymptomatic.

As shown in Table 1, ongoing assessment and treatment are critically important care components because

COVID patients can experience very rapid changes of condition when moving from asymptomatic to

critical in just a matter of hours, or if symptomatic and experiencing a rapid downturn in stability and/or onset of new life-threatening symptoms. Table 1 shows significant nursing intensity of care needs among the two COVID-positive status categories above and beyond the CDC COVID-19 Standard Precautions guidelines furnished to all residents. Both the enhanced clinical care needs and the enhanced CDC "transmission-based precautions" require far more professional nursing direct care activities regardless of whether a patient is in single-occupancy or cohorted occupancy isolation.

Table 1. Elevated Nursing Care Needs for COVID-Positive Patients Regardless of Single-Occupancy Isolation or Cohorted Multiple-Occupancy Isolation

COVID-Positive, Symptomatic	COVID-Positive, Asymptomatic
• **Requires nursing time for ongoing assessment of vital signs including oxygen saturation levels which typically is not a regularly monitored vital sign** • **Far more frequent positioning and repositioning patients due to breathing challenges and because patients are more sedentary which increases risk of bed sores** • **Delivery of inhalation treatment which involves moving roommate, and ensure the ventilation is appropriate due to droplet effect** • **Additional medication management – more complex and new medications such as**	• **Requires nursing time for ongoing assessment of vital signs including oxygen saturation levels which typically is not a regularly monitored vital sign** • **Additional medication management – more complex and new medications such as monoclonal antibodies drugs – training, how to deliver it, side effects, drug-drug interactions** • **Far more frequent ongoing assessments of – respiratory, GI, cardio-pulmonary function** • **Communication with physicians** • **Coordinating services not normally delivered in SNFs such as dialysis**

• monoclonal antibodies drugs – training, how to deliver it, side effects, drug-drug interactions • Far more frequent ongoing assessments of – respiratory, GI, cardio-pulmonary function • Multiple daily contacts with physicians as status changes • Nutrition – a) Individual Dining; b) Time for feeding to prevent aspiration; c) coordination of changing diets as needs change; and d) hydration. Monitors for proper hydration and eating is particularly important due to lack of taste and smell (e.g., decreased appetite) • Coordinating services not normally delivered in SNFs such as dialysis	• Often shift to symptomatic status needing additional nursing care described in left column

In Table 2 we provide an example of the average extensive direct nursing care necessary to care for COVID-19 positive patients in a dedicated 10 bed COVID unit derived from CMS Payroll-Based Journal (PBJ) data specific to unit nursing staff. Depending on the clinical acuity of the COVID unit, the care and the time spent with each patient on a COVID unit/area is similar regardless of whether the patient is in a single-occupancy or multiple-occupancy cohorted isolation room. As can be seen, although there may be minor efficiencies associated with cohorted patients, the nursing-only average hours per patient day (HPPD) of 5.2 equates to 312 nursing minutes per-day per resident for COVID-19 patients, which clearly aligns with the ES1 nursing component clinical category average wage-weighted staff time (WWST) of 303 minutes discussed in Section E and reflected in Table 4 of this Appendix. Most notably, the HPPD nursing hours within this COVID unit markedly surpassed the average WWST nursing hours of all the lower twenty nursing component CMG groups. Specifically, as depicted in Table 4 in Section E of this Appendix, the real-world COVID unit PBJ nursing hours per day surpassed the next lowest nursing component category (HDE2) by over one hour per day).

Table 2: Real-World Example of Ten Bed COVID Unit Nursing Resource Use

Job Role	Hours Per Day (10 Beds)	HPPD
Nurse Manager (RN)	**4**	**0.40**
RN	**12**	**1.20**
LPN	**12**	**1.20**
STNA	**24**	**2.40**
Total	**52**	**5.20**

4. ***The COVID-19 Blanket Waivers and Lack OF MDS Coding Flexibilities Have Been Insufficient to Accurately Identify and Reimburse for the Clinical Complex Care Needs of COVID-positive Patients Placed in Multiple-Occupancy Isolation Following CDC and CMS Guidance***

AHCA Position:

- **The current CMS MDS coding policy for active infectious disease requiring an isolation level of care and associated PDPM classification methodology does not recognize the elevated clinical care needs of COVID-positive patients placed in multiple-occupancy cohorted isolation, and instead reimburses providers as if the patient did not have an active infectious COVID-19 diagnosis.**

In response to the declared nationwide COVID-19 PHE, effective March 1, 2020, CMS waived the following requirement for nursing facilities[7] which effectively directed SNFs to follow CDC guidelines to *"place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents."* The rationale provided in the blanket waiver was *"solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19."*

> **Resident Roommates and Grouping.** CMS is waiving the requirements in 42 CFR 483.10(e) (5), ~~(6)~~ (Terminated on 05/10/2021 per QSO-21-17), and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19. This action waives a facility's requirements, under 42 CFR 483.10, to provide for a resident to share a room with his or her roommate of choice in certain circumstances, ~~to provide notice and rationale for changing a resident's room~~, and to provide for a resident's refusal a transfer to another room in the facility. This aligns with CDC guidance to preferably place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents.

In other words, the CMS COVID-19 PHE waiver guidance indicates that in the absence of an available single-occupancy room, then a resident could be cohorted in a multiple-occupancy room if the resident has an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission that meets criteria 1 of the MDS isolation item O0100M.

AHCA presents the following evidence justifying our request that CMS modify the isolation policy to mitigate for significant PDPM rate disparities when following CMS and Centers for Disease Control (CDC) public health guidance to cohort patients with active and highly transmissible disease during public health emergencies (PHE) or other local situations.

Historically, SNF patients that require isolation and treatment for *"highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission"* have been classified into one of the highest intensity Nursing component extensive services case-mix groups based on time study analyses. The SNF Minimum Data Set Resident Data Set Resident Assessment Instrument (MDS-RAI) directs that SNFs may only code MDS item *O0100M2 – Isolation or Quarantine for Active Infectious Disease* if a resident requires transmission-based precautions, is placed in single room isolation, and remains in the room[1]. Under PDPM, Medicare patients the MDS isolation or quarantine

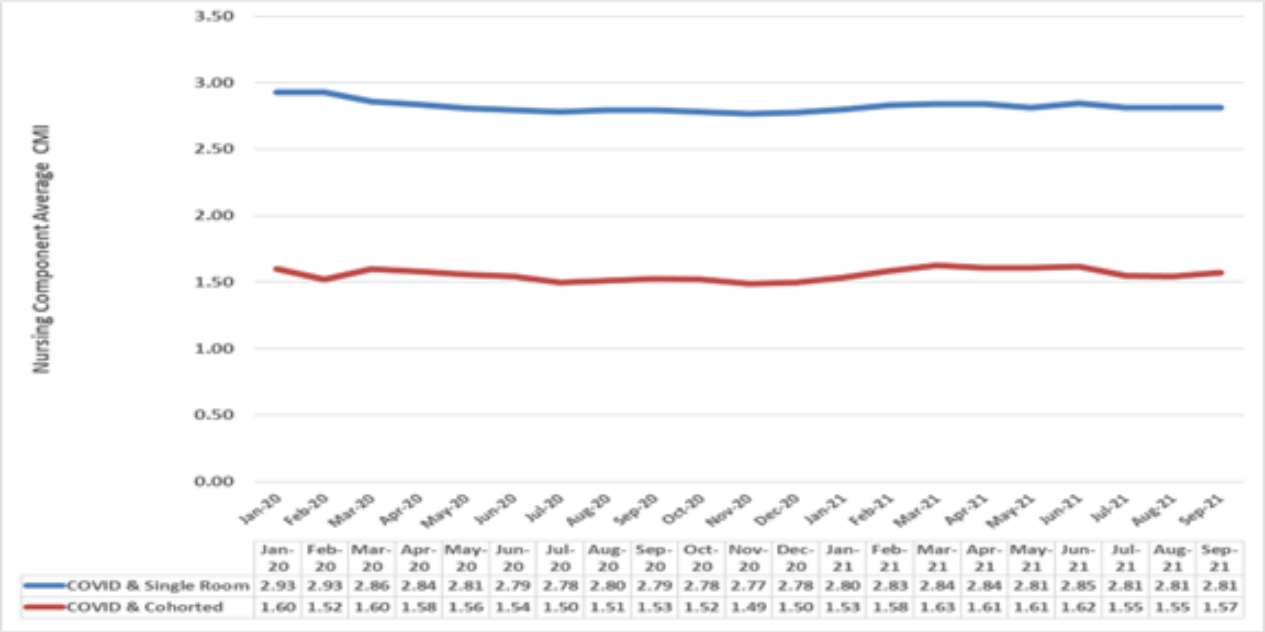
item reported are classified into the ES1 Nursing component case-mix group (CMG). This isolation item is also assigned one non therapy ancillary (NTA) component point, which could elevate patients into the next higher NTA CMG.

During the COVID-19 PHE, with massive numbers of quickly spreading cases overwhelming hospitals and SNFs, CMS recognized there was an insufficient capacity of single occupancy isolation rooms and issued blanket waivers effective March 1, 2020, permitting *"grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19*[8]*."* The waiver further specifies that cohorting residents *"aligns with CDC guidance to preferably place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents."*

Per AHCA analysis, from January 2020 through September 2021 there were 521,570 SNF PPS MDS assessments containing a diagnosis code of an active COVID-19 infection with 80.9% of patients located in urban counties. During this time span, only 44.9% of patients with an active COVID-19 infection were able to be isolated into a single occupancy room. The remaining 287,379 beneficiaries were in cohorted quarantine following CMS guidelines and therefore were ineligible for the Nursing component ES1 classification or the additional NTA point. **The PDPM case-mix classification of all COVID-positive patients in cohorted isolation defaulted to lower valued CMGs as if the patient's active COVID-19 condition requiring significant care needs did not exist.**

The devastating impact of this policy shortfall is reflected in Figure 1 depicting the monthly average Nursing component CMIs for SNF Medicare patients in urban locations with an active COVID-19 diagnosis. The blue line shows that patients in single room isolation had nursing component monthly average CMIs ranging from 2.77 to 2.93, which were nearly double the 1.49 to 1.60 monthly average CMIs of those patients in cohorted room isolation (red line).

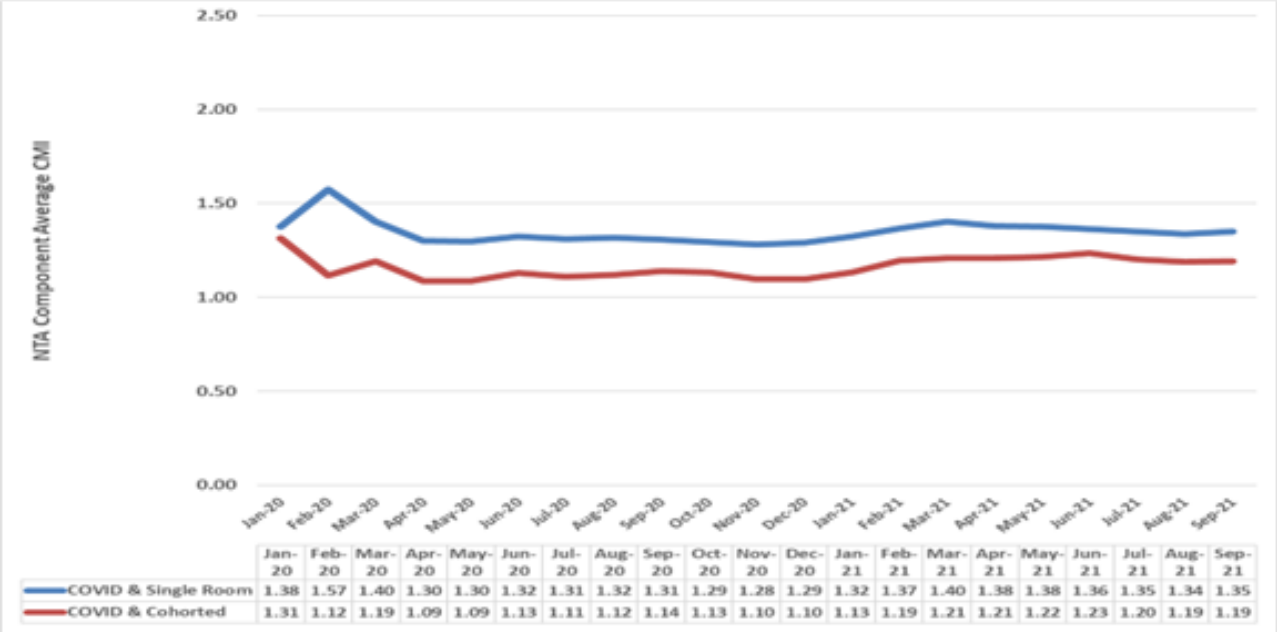
Figure 1. Nursing Component CMI Trends: Active COVID Diagnosis: Single Room vs Cohorted Isolation



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
COVID & Single Room	2.93	2.93	2.86	2.84	2.81	2.79	2.78	2.80	2.79	2.78	2.77	2.78	2.80	2.83	2.84	2.84	2.81	2.85	2.81	2.81	2.81
COVID & Cohorted	1.60	1.52	1.60	1.58	1.56	1.54	1.50	1.51	1.53	1.52	1.49	1.50	1.53	1.58	1.63	1.61	1.61	1.62	1.55	1.55	1.57

In a similar but less dramatic manner, Figure 2 depicts the monthly average NTA component CMIs for SNF Medicare patients in urban locations with an active COVID-19 diagnosis. Here, the blue line shows that patients in single room isolation had NTA component CMIs which were about 15% higher than those of patients in cohorted room isolation (red line).

Figure 2. NTA Component CMI Trends: Active COVID Diagnosis: Single Room vs Cohorted Isolation



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
COVID & Single Room	1.38	1.57	1.40	1.30	1.30	1.32	1.31	1.32	1.31	1.29	1.28	1.29	1.32	1.37	1.40	1.38	1.38	1.36	1.35	1.34	1.35
COVID & Cohorted	1.31	1.12	1.19	1.09	1.09	1.13	1.11	1.12	1.14	1.13	1.10	1.10	1.13	1.19	1.21	1.21	1.22	1.23	1.20	1.19	1.19

The impacts on total PDPM per-diem rates were substantial. Table 3 includes the average CMI and federal per-diem rate impacts for each PDPM component observed for all patients with an active COVID-19 diagnosis, comparing patients in single room versus cohorted room isolation during both FY 2020 and FY 2021. It is striking that while there were nominal differences in CMIs and payments for the PT, OT, and SLP components for COVID patients across all variables, there were substantial differences in the Nursing and NTA components. As depicted by the cells with bold text, the net daily reimbursement difference for cohorted COVID-19 patients was nearly $150 per day in urban and rural locations across both years, driven by significant CMI inequities in the Nursing and NTA components for active COVID patients that were placed in cohorted quarantine.

Table 3. Per Diem Rate Impacts: Active COVID Diagnosis: Single Room vs Cohorted Isolation

		FY 2020 (Jan-Sept 2020)			FY 2021		
		COVID & Single Room Average CMI	**COVID & Cohorted Room Average CMI**	**FY 2020 Per Diem Difference Single Room vs Cohorted**	**COVID & Single Room Average CMI**	**COVID & Cohorted Room Average CMI**	**FY 2021 Per Diem Difference Single Room vs Cohorted**
Urban	PT Component	1.41	1.41	$0.01	1.44	1.43	-$0.27
	OT Component	1.43	1.43	-$0.03	1.46	1.46	-$0.28
	SLP Component	1.88	1.93	$1.13	1.76	1.86	$2.26
	Nursing Component	**2.81**	**1.54**	**-$133.96**	**2.79**	**1.53**	**-$136.60**
	NTA Component	**1.31**	**1.11**	**-$15.93**	**1.32**	**1.14**	**-$14.76**
	Net Difference in Per Diem Rate			**-$148.78**			**-$149.64**
Rural	PT Component	1.40	1.40	-$0.12	1.42	1.41	-$0.47
	OT Component	1.43	1.42	-$0.15	1.44	1.44	-$0.44
	SLP Component	1.84	1.87	$0.72	1.73	1.79	$1.64
	Nursing Component	**2.72**	**1.45**	**-$128.53**	**2.70**	**1.46**	**-$128.18**
	NTA Component	**1.26**	**1.05**	**-$15.97**	**1.29**	**1.09**	**-$15.80**
	Net Difference in Per Diem Rate			**-$144.04**			**-$148.78**

AHCA believes that there are no differences in the care needs of Medicare beneficiaries with an active COVID-19 or similar highly transmissible infection that justify maintaining an arbitrary

and inflexible isolation coding policy that penalizes providers for following public health guidance. **We again emphasize that both the PDPM nursing and NTA component classification of cohorted isolation patients defaulted to lower valued CMGs as if the patient's active COVID-19 condition requiring significant care needs did not exist.**

5. ***The Current PDPM Nursing Component Classification Design Can Be Modified to Improvement Payment Accuracy for Patients with Active Infectious Disease Placed in Cohorted Isolation during a PHE or other local situations.***

AHCA Position:

- **If CMS determines there are no substantial differences in the direct nursing care time required between active infectious patients placed in single-occupancy isolation versus multiple-occupancy cohorted isolation, then the PDPM payment model should be modified in a manner that permits cohorted patients otherwise meeting the isolation criteria to be classified in the PDPM Nursing Component ES1 classification group, or**
- **If CMS determines that there are some efficiencies in direct nursing care time between active infectious patients placed in single-occupancy isolation versus multiple-occupancy cohorted isolation, then the PDPM payment model should be modified in a manner that permits cohorted patients otherwise meeting the isolation criteria to be classified in the PDPM Nursing Component HDE2 classification group as a proxy for the reduced nursing direct care time efficiencies. As depicted by the green row in Table 4, the HDE2 CMG reflects a nursing direct WWST of 249 minutes per day, which would be a much better representation of the COVID-positive patient nursing direct care time when in cohorted isolation than the currently observed CMI averages depicted in Table 3.**

While the PDPM and payment case-mix payment rates seek to reflect patient-specific care needs determined for each individual component, they do not address the resources required by COVID-19 patients when cohorted in multiple-occupancy room isolation. Per the April 2018 Skilled Nursing Facilities Patient-Driven Payment Model Technical Report prepared by Acumen, LLC., the methodology to calculate CMIs was to capture variation in nursing utilization using only the staff time collected[9].

In Section 3.6.3 Acumen states, "To accomplish this, Acumen replicated the methodology described in the FY 2010 SNF PPS rule (74 FR 22236 through 22238) but classified the full STRIVE study population into nursing RUGs using the RUG-IV classification rules." The CMS contractor published average wage-weighted staff time (WWST) data in Table 69 of the April 2018 Skilled Nursing Facilities Patient-Driven Payment Model Technical Report. Additionally, AHCA reviewed all the Staff Time and Resource Intensity Verification (STRIVE) Project reports and appendices cited by CMS in the proposed rule and found no evidence of nursing component costs associated with the design of the nursing component CMI weights beyond direct care time of the nursing staff as reflected in the WWST values reported.

As CMS is aware, the Acumen report Table 69 table lists the average WWST and aligned CMI for each of the twenty-five nursing component case-mix groups. We have updated that table by adding a column reflecting the resultant FY 2022 CMIs and unadjusted Urban per-diem payment rate for the 25 nursing component groups as depicted in Table 4 below.

Table 4: FY 2022 PDPM Nursing Component Groups

Nursing RUG	Nursing GG-based Function Score	# of Stays	% of Stays	Nursing WWST	CMI	FY 2021 Urban
ES3	0-14	5,767	0.3%	420	4.06	$444.61
ES2	0-14	10,738	0.6%	318	3.07	$336.20
ES1	0-14	20,487	1.1%	303	2.93	$320.86
HDE2	0-5	6,723	0.4%	249	2.40	$262.82
HDE1	0-5	71,884	3.8%	207	1.99	$217.92
HBC2	6-14	11,417	0.6%	231	2.24	$245.30
HBC1	6-14	169,690	9.1%	192	1.86	$203.69
LDE2	0-5	7,444	0.4%	215	2.08	$227.78
LDE1	0-5	109,411	5.8%	179	1.73	$189.45
LBC2	6-14	8,713	0.5%	178	1.72	$188.36
LBC1	6-14	184,464	9.8%	148	1.43	$156.60
CDE2	0-5	7,549	0.4%	194	1.87	$204.78
CDE1	0-5	114,067	6.1%	168	1.62	$177.41
CBC2	6-14	17,852	1.0%	160	1.55	$169.74
CA2	15-16	2,048	0.1%	113	1.09	$119.37
CBC1	6-14	467,881	25.0%	138	1.34	$146.74
CA1	15-16	48,634	2.6%	98	0.94	$102.94
BAB2	11-16	1,004	0.1%	108	1.04	$113.89
BAB1	11-16	56,861	3.0%	102	0.99	$108.41
PDE2	0-5	2,054	0.1%	163	1.57	$171.93
PDE1	0-5	88,198	4.7%	153	1.47	$160.98
PBC2	6-14	5,621	0.3%	125	1.22	$133.60
PA2	15-16	295	0.0%	73	0.71	$77.75

PBC1	6-14	425,809	22.7%	115	1.13	$123.75
PA1	15-16	28,656	1.5%	69	0.66	$72.28

Notable within the nursing component design of the Extensive Services clinical category group in Table 4 (highlighted in yellow) is that other than a requirement for at least a minimal functional impairment, the only qualifying requirement involving clinician effort is the direct care nursing time for services reflecting significant nursing WWST, including tracheostomy care (ES3), ventilator/respirator care (ES2), and/or isolation or quarantine (ES1). While a small percentage of patients with COVID-19 require tracheostomy care (ES3) or ventilator/respirator care (ES2), reflecting the most intensive amounts of nursing care, the majority of symptomatic and highly contagious confirmed COVID-19 patients require a significantly elevated level of assessment, treatment, and elevated transmission-based precautions for infection control efforts to meet the needed isolation or quarantine (ES1) level of care with a WWST average per patient day of 303 minutes (about 5 hours) direct care time and a CMI of 2.93. As demonstrated in Table 3, the PDPM payment model responded very well in applying appropriate CMI rate multipliers for COVID-positive patients placed in single-occupancy isolation as the Urban and Rural CMIs for these patients averaged 2.80 and 2.71 respectively across both years – which were comparable to the Table 4 nursing component ES1 - Isolation clinical group CMI of 2.93.

In contrast, the Table 3 Urban and Rural average CMI rate multipliers for COVID-positive patients placed in multiple-occupancy cohorted isolation of 1.54 and 1.46 respectively across both years are substantially lower than the ES1 clinical group CMI rate multiplier. Instead, as depicted by the lower red row in Table 3, the Urban component average CMI value of 1.54 is more comparable to the Nursing Component CBC2 clinical group which Table 4 describes services only requiring 160 minutes (about 2 and a half hours) of daily WWST compared to the 303 minutes reflected by the ES1 clinical group. Similarly, as depicted by the upper red row in Table 4, the Rural component average CMI value of 1.46 is more comparable to the Nursing Component LBC1 clinical group which Table 4 describes services only requiring 148 minutes (about 2 and a half hours) of daily WWST compared to the 303 minutes reflected by the ES1 clinical group.

While AHCA recognizes that there may be nominal direct nursing care time efficiencies realized by cohorting COVID-positive patients in multiple-occupancy isolation rooms, it is in no manner rational for the PDPM payment model to ignore the significantly elevated clinical nursing direct care needs of COVID-positive patients and reimburse providers at half the component rate of single-occupancy isolation patients.

6. ***The Current PDPM NTA Component Classification Design Can Be Modified to Improvement Payment Accuracy for Patients with Active Infectious Disease Placed in Cohorted Isolation during a PHE or other local situations.***

AHCA Position:

- **The PDPM payment model should be modified in a manner that permits cohorted patients otherwise meeting the MDS isolation criteria to be credited with the NTA component value of one point currently assigned to MDS item O0100M2 so that patients at a threshold for being classified into the next higher NTA CMG will be credited with the higher clinical complexity CMG weight.**

Per CMS, the NTA component utilizes a calculated NTA comorbidity score total to assign the patient to an NTA component classification group, which is determined by the presence of comorbidities and/or the use of extensive services[10]. The NTA component contains per-diem payment rates for six CMGs based on the average costs for high-cost drugs, biologics and equipment associated with patients with certain conditions or extensive service needs when such services are not statutorily excluded from Medicare SNF consolidated billing requirements. The *PDPM Calculation Worksheet for SNFs* in Chapter 6 of the MDS manual details how a list of 50 different conditions or extensive services are assigned point values from one to eight[7]. All points attributed to a patient are added together, and the patient is then assigned to one of the six NTA component CMGs.

One of the extensive services listed in the NTA component is whether the MDS item *O0100M2 - Special Treatments/Programs: Isolation Post-admit Code* is checked. If this item is checked, then the patient is assigned one NTA point towards the component classification calculation. Since under CMS current policy, if an active infections patient is placed in a multiple-occupancy cohorted isolation room following government public health guidance, their need for an isolation level of care cannot be attributed on the MDS and they would be ineligible for the one NTA component extensive services point assigned to the need for isolation.

As depicted in the far-right column of Table 5, if a cohorted isolation patient is at the number of points just below the next higher valued NTA component group, the potential NTA component per-diem base rate shortfall for urban providers ranges from a negative $19.83 per day to a negative $58.66 per day, and this shortfall is tripled during days 1-3 of the SNF stay due to the PDPM variable per-diem rate policy.

Table 5. NTA Case-Mix Groups and Per-Diem Rate Impact if Cohorted Isolation COVID Patients Cannot be Coded as Isolated on the MDS – Unadjusted Federal Urban Rates

NTA Score Range	NTA Case-Mix Group	NTA Case-Mix Index	NTA Per-Diem Rate	NTA Per-Diem Rate Shortfall if Cohorted & One Point Short of Next Threshold
12+	NA	3.24	$267.69	$58.66
9-11	NB	2.53	$209.03	$57.01
6-8	NC	1.84	$152.02	$42.14
3-5	ND	1.33	$109.88	$30.56
1-2	NE	0.96	$79.32	$19.83
0	NF	0.72	$59.49	N/A

As we mentioned above, SNF providers are responsible to pay for the costs of furnishing all necessary drugs, biologics and equipment not statutorily excluded from SNF consolidated billing requirements[11]. However, because COVID-19 is a novel virus, and for any novel virus, there is no available statutory exclusion from consolidated billing regardless of the costs for such NTAs. Additionally, due to the nature of a novel virus, PDPM was not designed in a manner to capture NTA costs associated with the new disease. For example, during the COVID-19 PHE, many new COVID-19 treatments including monoclonal antibodies, not excluded from consolidated billing and not contemplated for a worldwide pandemic requiring cohorted isolation, in many SNFs cost the SNF hundreds of dollars per treatment[12].

This situation is worsened in cases where an active infectious patient in cohorted isolation cannot be classified on the MDS as needing and receiving an isolation level of care. In contrast, CMS adopted a policy establishing the New COVID-19 Treatments Add-on Payment (NCTAP) program from November 2020 through the need of the PHE *"designed to mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments."* These payments, outside of the hospital prospective payment system payment model cover the provider costs for new high-cost COVID 19 treatments including Remdesivir[13]. CMS also separately pays for these treatments in outpatient settings.

It is inexplicable to AHCA that CMS PHE policy does not protect beneficiary access to such needed new high-cost treatments furnished in the SNF as it does for hospital and outpatient settings. For hospitals, CMS recognizes that the exorbitant unanticipated costs of new COVID-19 treatments are not accounted for in the hospital prospective payment system and therefore an add-on payment is available to cover the costs so that patient access to such needed treatments is protected. In contrast, these new and unanticipated costs are bundled into the existing SNF PPS PDPM payment model pricing structure for all such patients, and the negative fiscal impact is worsened for providers that need to isolate COVID patients needing these treatments in a multiple-occupancy room when there are no single-occupancy isolation rooms available.

The AHCA request for CMS to modify the current isolation coding policy to permit coding of cohorted isolation during a declared PHE or local situations following public health guidance when there are no single-occupancy isolation rooms available may not eliminate this policy discrepancy for new high-cost treatments between settings but would at a minimum help protect the beneficiary access to new approved treatments in the SNF setting.

7. Conclusion

AHCA appreciates the opportunity to provide comment regarding this RFI. We believe this issue is extremely important as is related to the question of whether the Payment Driven Payment Model (PDPM) adequately accounts for patient care needs associated with an active infectious disease requiring quarantine when following guidance provided by CMS and public health

officials. We strongly believe that the current CMS isolation coding and PDPM payment policies are inadequate to address patient care needs during the current COVID-19 public health emergency (PHE) and would continue to remain inadequate to address patient needs in future outbreaks of *"highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission."*

We understand that before adopting our recommendations and potential solutions, CMS would need to formally propose changes through the regulatory notice and comment process. AHCA would be happy to offer additional feedback and to respond to questions related to our RFI response comments. We look forward to further engagement with CMS to improve these unresolved isolation MDS coding and PDPM payment policy issues.

[1] CMS MDS RAI Manual, Version 1.17.1., October 2019 (link)

[2] 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (link)

[3] CDC. ICD-10-CM Official Coding Guidelines – Supplement Coding encounters related to COVID-19 Coronavirus Outbreak Effective: February 20, 2020 (link)

[4] ICD-10-CM Official Coding and Reporting Guidelines April 1, 2020 through September 30, 2020 (link)

[5] ICD-10-CM Official Guidelines for Coding and Reporting FY 2021 (October 1, 2020 - September 30, 2021) (link)

[6] ICD-10-CM Official Guidelines for Coding and Reporting FY 2022 -- UPDATED April 1, 2022 (October 1, 2021 - September 30, 2022) (link)

[7] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (link)

[8] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (link)

[9] Skilled Nursing Facilities Patient-Driven Payment Model Technical Report. April 2018. Acumen, LLC. (link)

[10] Fact6-8 Sheet: PDPM PatiNCent Classification (link)

[11] Overview on Skilled Nursing Facility (SNF) Consolidated Billing (CB): CMS SNF Consolidated Billing Page (link)

[12] CMS COVID-19 Vaccines and Monoclonal Antibodies webpage (link)

[13] CMS New COVID-19 Treatments Add-On Payment (NCTAP) webpage (link)

Section VI. Skilled Nursing Facility Quality Reporting Program

1. ***Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) Measure Beginning With the FY 2025 SNF QRP***

The following discussion includes the AHCA response to the following four interrelated sections of the proposed rule pertaining to the proposed new Influenza Vaccination Coverage Among Healthcare Personnel (HCP) measure (NQF #0431):

- ***Section C. SNF QRP Quality Measure Proposals Beginning With the FY 2025 SNF QRP (p.22745)***
- ***Section G. Form, Manner, and Timing of Data Submission Under the SNF QRP (p.22762)***
- ***Section H. Public Reporting of the Influenza Vaccination Coverage Among Healthcare Personnel (NQF #0431) Measure Beginning With the FY 2025 SNF QRP (p.22672)***
- ***Section B.1.3. Proposed Revisions to the Regulation Text (§ 413.360) (p.22753)***

CMS proposes to adopt the CDC developed Influenza Vaccination Coverage among HCP measure (NQF #0431) for the SNF QRP, as collected through the CDC's NHSN, to report the percentage of HCP who receive the influenza vaccine. CMS states a belief that this measure will encourage HCP to receive the influenza vaccine, resulting in fewer cases, less hospitalizations, and lower mortality associated with the virus. CMS proposes the measure will have a 100% performance threshold for to avoid the SNF QRP 2% payment adjustment beginning with the FY 2025 SNF QRP based on an October 1, 2022 through March 31, 2023 performance period. Additionally, CMS proposes to publicly report the reported HCP influenza vaccination rate for the October 1, 2022 through March 31, 2023 performance period on the Nursing homes including rehab services website within Care Compare and the CMS Provider Data Catalog webpage beginning October 1, 2023.

AHCA Comment:

- **AHCA does not support the implementation of this measure as proposed.**
- **The measure requires provider protections to mitigate NHSN data submission issues beyond a provider's control.**
- **The measure requires adequate data validation and provider review and correction processes comparable to other provider submitted SNF QRP data before AHCA can support this measure for SNF QRP 100% data completion threshold, payment adjustment, or public reporting purposes.**

AHCA appreciates the importance of influenza vaccination uptake by SNF healthcare personnel, and we encourage providers to educate staff about the vaccine and develop approaches to facilitate such uptake. However, we have concerns about both the proposed measure

specifications and the proposed reporting schedule to achieve the SNF QRP data submission performance requirements and to assure that the most accurate data is publicly reported.

Proposed Measure Specifications: This is a process measure that reflects potential structural quality risks at a building level that does not provide a risk-adjusted comparison of the quality of patient care or outcomes. This is a measure of uptake of a non-mandated vaccine by SNF personnel, and results could be skewed significantly depending on a staff member's right to decline the vaccine based on religious or ethnic beliefs is handled. While a provider's performance on this measure for the potential SNF QRP 2% payment adjustment penalty technically only requires a minimum of a one-time data submission to the CDC HCP influenza data reporting module in the NHSN HPS Component, there are submission challenges that need to be considered.

Proposed Submission Requirements: The proposed data submission process through NHSN with at least one data file appears to be reasonable on the surface, there are numerous unresolved issues that without adequate processes for data validation and provider notice and opportunity to correct, we anticipate a considerable number of providers would become subject to the full brunt of the 2% SNF QRP payment adjustment penalties for issues beyond their control.

Specifically, the data submission process requires the collection of data obtained from any healthcare personnel (employed, contracted, or non-employed direct care professionals including physicians) that furnish at least one day of care between From October through April. The provider then completes and submits two forms no later than May 15 of each year containing the required numerator and denominator data applicable to the October through April performance period. It is not clear in this proposed rule whether there are any provider protections for data submission event issues beyond their control.

Before we discuss some of the HCP influenza vaccination measure data submission challenges, we would first like to comment on the CMS statements about how many nursing home providers are currently voluntarily submitting HCP influenza vaccination data to the CDC NHSN site and whether providers were able to review and or correct any of that voluntarily submitted data.

On page 22748 of the proposed rule, CMS states in a justification for proposing this measure and data submission process implying that the submission of this data is already commonplace.

Specifically, CMS stated:

> *"In fact, several thousand nursing homes voluntarily reported weekly influenza vaccination coverage through an NHSN module based on the NQF #0431 measure during the overlapping 2020 to 2021 influenza season and COVID–19 pandemic."* and
>
> *"Variation in influenza vaccination coverage rates indicate the proposed measure's usability and use. A CDC analysis during the 2020 to 2021 influenza season revealed that among 16,535 active, CMS-certified nursing homes, 17.3 percent voluntarily submitted data for the proposed measure through the National Healthcare Safety Network (NHSN)."*

AHCA members reported that these numbers did not reflect their experiences and we asked both CMS and CDC to confirm these reported numbers or share the study these statements were based on. CMS declined to offer any of the requested supporting analysis during this comment period. However, CDC responded to AHCA via email that per their records of the staff influenza vaccine module: "*For the 2020-2021 season, 47 LTCFs voluntarily reported, and 37 voluntarily reported data for the 2019-2020 season."*

AHCA believes it is implausible that *"several thousand"* nursing homes have submitted this data. Unlike the mandatory COVID-19 module that can be submitted with SAMS Level 1 security access, the annual influenza vaccine module is in the HPS component (protected due to person-level data) which means that it would require SAMS Level 3 access – which is a lengthy process and not one that can easily be achieved in a short amount of time if someone in the facility leaves, gets ill, goes on vacation, etc. It takes several weeks to gain SAMS Level 3 access. Some providers have reported confusion with the NHSN data submission requirements and indicated they unintentionally submitted data for certain modules that they were not aware were voluntary.

Numerous AHCA members have also reported to us about technical issues in submitting data to NHSN that already add significant administrative burden, taking care staff away from direct care activities, and that could result in submission problems. Some technical examples reported include:

- NHSN module tables and required content change frequently.
- NHSN system may accept data that is not complete leading to non-compliance.
- Provider CCN's are somehow getting mixed up with other facility CCNs within NHSN.
- There have been several times over the last two years that comma separated items on group uploads is not working and causes errors within the NHSN system.
- The auto-populated error messages that pop-up in NHSN do not identify where the error in data is located. Facilities spend a lot of time (in some instances hours) trying to track down what the error is.
- There have been delays in NHSN Help Desk responses and they often close a ticket without ensuring a resolution with the facility.
- Provider software incompatibility and ransomware attacks have prevented transmission of files.
- Telecommunication company transmission unavailable (i.e., weather-related interruptions).

CMS also states in their justification a large variance in the staff vaccination coverage reported via the NHSN module as follows:

> *Average staff influenza vaccination coverage was approximately 64 percent, ranging from 0.3 percent to 100 percent with an interquartile range of 40 to 93.9 percent. Variation in influenza vaccination coverage rates by facility demonstrates the utility of the measure for resident choice of facility. Variation in influenza vaccination rates by type of HCP demonstrates the utility of the proposed measure for targeted quality improvement efforts.*

Some providers have reported to AHCA confusion with the NHSN data submission requirements and indicated they sometimes unintentionally submitted data for certain modules that they were not aware were voluntary and without a clear understanding of the specific requirements for these voluntary modules. Even if *"several thousand"* providers submitted a staff influenza data file into NHSN as CMS purports, it is unclear from the proposed rule whether any of this voluntarily submitted data was subject to any quality checks or providers had an opportunity to review and correct, so the reported large variance may not reflect reality. It is also not clear to AHCA whether the CMS proposed review and correct process applies only to the public reporting portion of this new measure, or the quality reporting portion as well. It appears that CMS will not accept any corrections submitted to NHSN after May 15 so how will a provider be able to correct any discrepancies identified in a provider preview report that CMS would issue in July? AHCA seeks that CMS clearly articulates that for any NHSN reported data, CMS provides review and correct protections comparable to other self-reported assessment-based data in the SNF QRP program.

CMS proposes to add new and conforming language to the regulation text (§ 413.360) to state that SNFs must meet or exceed two separate data completeness thresholds: One threshold set at 80 percent for completion of required quality measures data and standardized patient assessment data collected using the MDS submitted through the CMS-designated data submission system, beginning with FY 2018 and for all subsequent payment updates; and a second threshold set at 100 percent for measures data collected and submitted using the CDC NHSN, beginning with FY 2023 and for all subsequent payment updates.

It remains unclear to AHCA what the 100 percent threshold means. Does it simply mean that a file was submitted to NHSN at least once per month for the COVID-19 measure and at least one file was submitted between April 1 and May 15 each year for the influenza vaccine measure, or other future measure data submitted to NHSN, or must this data also meet other data completion thresholds? Again, if AHCA seeks that CMS clearly articulates that for any NHSN reported data, CMS provides review and correct protections comparable to other self-reported patient assessment data in the SNF QRP program, particularly with a proposed 100% completion threshold.

2. Revised Compliance Date for Certain Skilled Nursing Facility Quality Reporting Program Requirements Beginning With the FY 2024 SNF QRP (p.22750)

CMS proposes to revise the reporting date for the previously adopted Transfer of Health Information (TOH) measures MDS items, and other standardized patient data elements in the MDS. These items were intended to be implemented in October 2020, but that implementation was delayed due to the COVID-19 PHE along with other technical issues. The current requirement is that these items would be reported beginning with the first FY 2 years after the end of the COVID-19 PHE, along with the updated version of the MDS 3.0 v1.18.11. CMS proposes to accelerate the date for implementing these MDS items along with the updated MDS 3.0 v1.18.11 to October 1, 2023.

AHCA Comment:

- **AHCA supports the revised reporting date for the TOH measures MDS items, and other standardized patient data elements in the MDS with the updated version of the MDS 3.0 v1.18.11 from the current date of first FY 2 years after the end of the COVID-19 PHE to October 1, 2023 as proposed**.

3. ***SNF QRP Quality Measures Under Consideration for Future Years: Request for Information (RFI) (p.22754)***

CMS is requesting comments on quality measure concepts to be considered in future rulemaking. AHCA appreciates the opportunity to provide some initial insights on these concepts, and we understand that CMS will not be responding to specific comments submitted in response to this RFI, but that the Agency intends to use this input to inform future measure development efforts.

a. ***CMS is seeking input on*** *a single cross-setting functional measure that would incorporate the domains of selfcare and mobility as an alternative to the four current redundant measures as discussed during a recent PAC TEP.*

AHCA Comment:

- **AHCA members have been pleased to participate in the technical expert panel discussions to date and we support the continued development efforts of the measure concept.**

Such cross-setting measures could help advance the vision of the IMPACT Act by having measures follow the patient. We also believe that any opportunity to obtain meaningful functional outcomes data with less redundancy than the current multiple overlapping functional outcomes measures would also help reduce administrative burden. However, since currently 47 percent of Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans, and this number is expected to grow to be the majority of beneficiaries in the near future, we believe that CMS should also explore the potential need of extending the cross-setting functional measures to include MA and fee-for-service (FFS) admissions to truly represent the Medicare population, and not just the diminishing number of FFS patients.

b. **CMS is seeking input on** measures of health equity, such as structural measures that assess an organization's leadership in advancing equity goals or assess progress towards achieving equity priorities.

AHCA Comment:

- **AHCA supports the continued development efforts of measure concepts to address health equity.**

However, we caution against advancing numerous and time consuming structural and process measures that demonstrates an organization is good at "checking the box" that they did what was asked on a quality measure checklist. We would prefer efforts be directed at exploring the thoughtful development of meaningful and adequately risk-adjusted outcomes measures that demonstrate that the facility is showing progress at overcoming such historical barriers to quality care.

c. **CMS is seeking input on** the value of a COVID–19 Vaccination Coverage measure that would assess whether SNF patients were up to date on their COVID–19 vaccine.

AHCA Comment:

- **AHCA believes that vaccines are a very important public health intervention, but we strongly oppose developing another new static vaccine process measure as an automatic response for specific diseases or variants or definitions of what "up to date" means, which could result in multiple new burdensome measures for each novel disease with vacillating impacts.**

Vaccine hesitancy is a social issue that cannot be addressed by a process measure. Quality measures should be developed deliberatively for incentivizing provider behaviors primarily within their control. We believe that existing regulatory quality of care and CDC reporting requirements and enforcement processes are sufficient to address all the fluctuating medical, religious, and other vaccine hesitancy nuances involved with encouraging vaccination that cannot be expressed in a simplified pre-established process measure that is unable to be immediately adapted to shifting public health guidance.

4. ***Overarching Principles for Measuring Equity and Healthcare Quality Disparities Across CMS Quality Programs—Request for Information (RFI) (p.22754)***

CMS is seeking input on the principles and approaches as well as additional thoughts about disparity measurement guidelines suitable for overarching consideration across CMS' QRP programs. AHCA understands that while CMS will not be responding to specific comments submitted in response to this RFI, submitted comments will be considered as the agency develops future regulatory proposals or future sub-regulatory policy guidance. Any updates to specific program requirements related to quality measurement and reporting provisions would be addressed through separate and future notice-and-comment rulemaking, as necessary.

AHCA Comment:

- **AHCA supports the continued development efforts of measure concepts to address health equity and disparities across CMS quality programs.**

However, we caution against advancing numerous and time consuming structural and process measures that demonstrates an organization is good at "checking the box" that they did what was asked on a quality measure checklist. We would prefer efforts be directed at exploring the thoughtful development of meaningful and risk-adjusted outcomes measures that demonstrate that the facility is showing progress at overcoming such historical barriers to quality care.

- **AHCA members have long supported the IMPACT Act intent of collecting standardized data elements across all provider settings that is meaningful and that supports ongoing improvement in providing cost-effective care and achieving patient satisfaction.**

We recognize the complex challenges in furnishing high quality care to beneficiaries that possess currently unaccounted for characteristics that may impact their access and responsiveness to care and resultant costs and outcomes. Our analysis of the disproportionate impacts of social determinants of health and demographics of underserved populations on related to PDPM case-mix shift trends during the COVID-19 PHE discussed in the SNF PPS PDPM parity adjustment comments elsewhere in this comment letter highlight this need for additional study. Such factors require further evaluation prior to any consideration of revising payment, quality measurement, or value-based incentive programs to avoid potential perverse incentives or public misrepresentation of a provider's quality of care that could perpetuate, rather than reduce health disparities.

Below is a summary of additional feedback from the AHCA provider membership.

Need to Collect Better Social Risk, Racial, and Ethnic Data

AHCA is aware that numerous research studies have identified that social risk, racial, and ethnic factors play a role in access to care and in the outcomes of care. Collecting better data may help to determine where and what are the health inequities that need to be addressed. If so, segmenting quality data by social risk, race, and ethnicity may help provide direction to drive targeted quality improvement efforts.

Racial and ethnic data should be collected through current standardized resident assessment processes such as in item A1000 in Section A of the MDS assessment that addresses Race/Ethnicity. Revision of this item to be standardized across all settings would limit adding to staff burden as changes would be incorporated into an existing workflow and could be captured and automated by EHR systems.

Some social risk and social determinants of health factors that research studies have demonstrated to impact beneficiary equity and provider quality of care measurements, including dual eligibility to Medicare and Medicaid, may be readily available or made readily available via standardized information entered on the MDS However, revising or adding data elements of more detailed standardized demographic and language data as well as items describing detailed beneficiary socioeconomic, cultural, and environmental determinants of health may be more challenging to obtain from beneficiaries or their representatives as well as be more burdensome should the volume of new items become excessive. We encourage CMS to be mindful of these concerns and assure that any proposed new items be thoroughly vetted via technical expert

panels as well as transparent public comment opportunities. CMS should consider revising gender identification options in MDS item A0800 – Gender, which currently only includes binary Male/Female options. To further minimize burden, any such items revised or added should only be required to be reported upon admission as they are unlikely to change during the resident stay.

Incorporating Social Risk, Racial, and Ethnic Data in the SNF QRP Measures

AHCA members have suggested to a conceptually, several existing measures could be considered for careful evaluation. These include successful discharge to community, potentially preventable rehospitalization, future proposed measures such as shared decision making, patient experience, transfer of health information to patient, and Medicare spend per beneficiary (MSPB) measures.

The MSPB measure may be the most appropriate measure to consider evaluating these factors as the beneficiary's personal and social supports situation often influence the SNF plan of care, length of stay, and likelihood of successful discharge to community as much if not more than the clinical presentation. Providers should not be incentivized to stint on care for a clinically similar but otherwise disadvantaged population to boost their MSPB measure results.

However, incorporating any of these factors into SNF QRP measures cannot be done until such standardized data elements are available across all provider settings and such data is analyzed.

Social risk, racial and ethnic data should only be incorporated for SNF QRP measures where such data have been shown through research/studies to have an impact on those specific QRPs. For example, considering the impact of such factors in beneficiaries with each outcome measure would help identify potential disparity issues. However, this could become murky very quickly without well researched and defined specifications as ethnic beliefs, health literacy, and nutrition could all sway outcomes. This is one reason we support the accelerated implementation of MDS version 1.18 on October 1, 2023 elsewhere in this comment letter, which will introduce several new or revised items standardized post-acute items related to healthcare equity and disparity quality measure development efforts.

Simply identifying discrepancies across different populations may not directly translate into inequity in SNF care. While we are concerned that under current SNF QRP measures, research suggests that providers furnishing services to certain apparently disadvantaged beneficiary populations appear to have lower quality scores, we are also concerned that adjusting the risk-adjustment criteria to reduce the provider quality score discrepancy could have an unintended consequence of disincentivizing currently lower scoring providers to improve care.

Additionally, these factors would be difficult to measure and risk-adjust since inequities will vary across the country depending on regional populations based on such factors as income, education, religion, culture, and others. Finally, these factors impact care across all PAC and other provider types and are typically outside of the SNF's influence and therefore should not be disproportionally weighted compared to factors within the SNFs ability to develop quality improvement strategies.

5. ***Inclusion of the CoreQ: Short Stay Discharge Measure in a Future SNF QRP Program Year—Request for Information (RFI) (p.22761)***

CMS Comment Request: In this proposed rule, CMS requesting stakeholder feedback on future adoption and implementation of the CoreQ: Short Stay Discharge Measure into the SNF QRP. AHCA appreciates the opportunity to provide our thoughts, and we understand that CMS will not be responding to specific comments submitted in response to this RFI, but that the Agency intends to use this input to inform future measure development efforts.

AHCA Comment:

- **AHCA supports the future adoption of the CoreQ: Short Stay Discharge Measure (NQF #2614) into the SNF QRP.**

AHCA agrees with the position of CMS stated in this proposed rule that *"To achieve the goal of patient-centered care, there must be a way to measure patient satisfaction since it is necessary to understand patient preferences. Measuring patients' satisfaction can also help organizations identify deficiencies that other quality metrics may struggle to identify, such as communication between a patient and the healthcare provider."* AHCA developed and obtained NQF endorsement in 2016 and achieved re-endorsement in 2020 for this measure because, like CMS, we agree that the *"Collection of patient experience data aligns with the person-centered care domain of CMS's Meaningful Measures 2.0 Framework and addresses an aspect of patient experience that is not currently included in the SNF QRP."* Many AHCA members already use CoreQ to collect and assess SNF patient satisfaction data as such data is important for understanding patient experiences and preferences. Such patient reported outcomes data are incorporated into QAPI strategies to help facilities improve their quality of care.

If adopted as a SNF QRP measure, such information shared nationwide could also be used to ensure that patients can easily and discretely share their information and provide information to help consumers choose a trusted SNF. However, we recommend that for the SNF QRP program, data collection should be conducted by an independent data collection vendor entity and not the SNF to both minimize facility data collection burden and to assure that the patient or patient proxy responses without interpretation of the patient's response by SNF personnel. As CMS indicates in the proposed rule, there are currently nearly 40 customer satisfaction vendors have incorporated or will incorporate CoreQ into their surveys, and this number would surely increase to meet needed capacity should CMS adopt this as a SNF QRP measure.

The following are the AHCA responses to the five specific questions proffered by CMS related to this RFI:

CMS Question #1: Would you support utilizing the CoreQ to collect PROs?

AHCA Response #1: Yes

CMS Question #2: Do SNFs believe the questions asked in the CoreQ would add value to their patient engagement and quality of care goals?

AHCA Response #2: Yes

CMS Question #3: Should CMS establish a minimum number of surveys to be collected per reporting period or a waiver for small providers?

AHCA Response#3: We believe that there is a good history with the currently re-endorsed NQF measure that has been available since 2016 that a facility must have at least 20 valid responses to meet the minimum requirements for the minimum sample size. We recommend that CMS continue to apply or build on the following specifications requirement described in the described in the CoreQ Satisfaction Questionnaire and User's Manual that CMS referenced in this proposed rule. That manual is available at http://www.coreq.org/CoreQ%20Satisfaction%20Questionnaire%20and%20User%20Manual.pdf.

> ***CoreQ Short-Stay Discharges:*** *Should be initially administered within two weeks of discharge from the center. The data collection should continue for the next six months or you may stop once you receive 125 or more valid responses. Please note you must have at least 20 valid responses to meet the minimum requirements for the minimum sample size (see Reporting Center's Results section for more information). These must be consecutive returns and cannot be the "best 125 responses". The questionnaire should be administered AFTER discharge not the day of discharge similar to the requirement for the Consumer Assessment of Health Care Providers and Systems (CAHPS) survey.*

CMS Question #4: How long would facilities and customer satisfaction vendors need to accommodate data collection and reporting for all participating SNFs?

AHCA Response #4: Similar to our response to Question #3, we believe that there is a good history with the currently re-endorsed NQF measure that has been available since 2016 that data collection should continue up to six months following discharge or until 125 or more valid responses have been received for a facility during the six-month response window.

CMS Question #5: What specific challenges do SNFs anticipate for collecting the CoreQ: Short Stay Discharge measure? What are potential solutions for those challenges?

AHCA Response #5: Because this NQF endorsed and re-endorsed measure has been in use since first endorsed in 2016, many of the kinks have been worked out. The primary challenge will be to assure that all providers have a customer satisfaction vendor assigned to collect responses to the survey as well as develop processes to submit the quality data to CMS. This will require a coordination of efforts between the provider and vendor to share patient discharge information necessary for administering the survey. Additionally, providers that have not used CoreQ in the past will require training on the measure like any other new SNF QRP measure implementation.

Section VII. Skilled Nursing Facility Value-Based Purchasing Program

VIII B.1.b proposed suppression of SNF RM for FY2023: We appreciate and support the proposal to suppress the SNFRM measure for the reasons outlined in the proposed rule. We support this approach that results in all SNFs receiving the identical performance score and hence an identical incentive payment multiplier (IPM).

Under the current proposal, CMS continues to return 60% of the 2% withhold rather than the maximum 70% that is allowed in statute. Given the nature of the pandemic, its impact on provider costs, we would argue that CMS should return more than 60% and as close to 70% understanding that CMS needs to set a IPM that does not inadvertently result in greater than 70% returned. CMS now has enough historical data to more accurately predict the impact an IPM will have and we suggest that at least 65% or more be returned.

VIII B.2.Technical updates to SNFRM risk adjustment. We appreciate CMS visiting the need to update the risk adjustment to incorporate COVID-19. We support the proposal to follow option 3 which incorporates having had COVID infection.

VIII B.3. Quality Measures Proposals for SNF VBP expansion with FY2026. We support the addition of additional measures to the SNF VBP program that are consistent with the intent and purpose of the program, but have concerns with two of the measures. The HAI measure has not been endorsed by NQF and relies on claims from the hospital to determine if an infection was potentially preventable. However, it is well known that hospitals miss and overdiagnosis infections among elderly, particularly urinary tract infections, urosepsis and other sepsis findings. This measure has not been tested for accuracy against medical record review that uses CDC guidelines for infection diagnosis in elderly nursing home residents. The Staffing measure is a structural measure that is inconsistent with the purpose of the SNF VBP to link payment to quality outcomes. Also, the measure proposed is a measure of staffing facility wide, not just post acute care. CMS has indicated on prior measures that only FFS beneficiaries should be included in the SNF RM and other measures, excluding managed care and other elderly. Lastly, the staffing measure may exacerbate disparities as SNFs with larger populations of minorities have lower staffing levels. By including this measure in VBP, it will take resources away from facilities most in need to hire more staff. We recommend that the HAI measure undergo better tests of accuracy and the staffing measure be excluded at this time.

VIII B.3.b. (1) Proposal to adopt the SNF HAI hospitalization measure. background

While we agree that there are interventions that can prevent infections, we are not aware of any studies that have looked at reduction of hospitalizations due to infections identified on claims. The logic that infections can be prevented – therefore this measure should be included is flawed since its unclear that measure can detect improvements and reductions in infections because the hospital incorrect diagnosis of infections masks improvements.

VIII B.3.b. (2) Proposal to adopt the SNF HAI hospitalization measure. Overview of measure

The proposed measure does not meet the definition of a HAI "an infection that is likely to be acquired during SNF care and severe enough to require hospitalization, or an infection related to invasive (not implanted) medical devices (for example catheters, insulin pumps, and central lines). The time window of only 4 days following admission to the SNF does not exclude many infections that were likely acquired prior to SNF admission. The incubation period of many infections are >4 days and the disease course leading up to infection takes a few days, as such many infections sent to the hospital after 4 days should not be attributable to the LTC and therefore should not be counted in the HAI measure to be consistent with the definition used to create the measure.

VIII B.3.b. (3) Proposal to adopt the SNF HAI hospitalization measure. Data sources

This measure bases the diagnosis of infection from claims and that if it's a LTC care acquired based on claim and time window after admission to the SNF. As mentioned, hospital claims are notoriously inaccurate and overdiagnosis infections, particularly UTI and urosepsis the two most common infections in this measure. Also, as just mentioned many of the infections are the result of infections

VIII B.3.b. (4) Proposal to adopt the SNF HAI hospitalization measure. Inclusion & exclusion criteria.

The list of exclusions makes sense but is incomplete. The time window or readmissions within 4 days of SNF admission is too short of time window. Most infections have incubation periods of 5 to 7 days and as such infection developing in the first week of SNF admission were likely acquired during the hospital stay. Then the infection usually needs a 1-3 days to get bad enough to result in hospitalization. So any admissions for HAI within the first 10 days should be excluded.

VIII B.3c. (1) Proposal to adopt total nursing hours per resident data (HPRD). Background

We disagree that this measure adds a new dimension for a more comprehensive assessment. As stated in the proposed rule, this is a process measure that while it has an evidence basis, it is not consistent across all measures and the RN level is much stronger and more relevant to this measure. Also we disagree this will drive improvement. The cost to achieve increases in staffing levels will be higher than the return of the 60% of the 2% cut in Medicare part a rates. Staffing costs are the dominant expense in nursing homes. To increase staffing, it will add costs that for many nursing homes will exceed the financial reward associated with this measure. This measure will contribute 1/3 to 60% of 2% cut. Thus, adding this measure to VBP creates a financial incentive to not increase staffing. As pointed out CMS has other mechanisms to drive staffing up including public reporting, five star rating and regulations.

VIII B.3c. (2) Proposal to adopt total nursing hours per resident data (HPRD). Overview

The data source for this measure is payroll base journal. The PBJ instructions create make the information collected inaccurate in two areas. First, any salaried individual, who many nurses are, have their hours capped at 40 hours per week, if they work extra shifts beyond 40 hours, those hours are not collected unless they are paid additional time for those hours. Since they are salaried, paying them extra funds is consistent with non-exempt employment, which they are not. Since as mentioned RN hours has the strongest relationship with quality, this policy undercounts RN hours. Second, PBJ automatically reduces hours worked for all employees aby 30 min each day for lunch/break time. In some states, this time is already taken out as they are not paid but in other states this time is recorded in the payroll. So in those state their payroll data already excludes 30 min, the additional PBJ reduction creates a lower HPRD. Therefore, since this raises questions about the accuracy of this measure and it has not undergone NQF review it should not be used in a payment program.

VIII B.3c. (4) Proposal to adopt total nursing hours per resident data (HPRD). Inclusion and exclusion criteria

We oppose using these suggested exclusion criteria for values that may be out of range. These cut offs are used in Five Star system by CMS but should not be used in the payment program without an appeals process. We have seen number of providers have accurate and correct values but fall beyond the limits proposed. This can happen in facilities that do very high acuity care and high proportion of post-acute care, those who the is program impacts the most. Some SNFs that provide very high acuity care, such as chronic vent care or have a majority of beds devoted to post-acute care.

VIII B.3c. (5) Proposal to adopt total nursing hours per resident data (HPRD). Case mix adjustment.

We agree that the measure needs to be case mix adjusted. However, the current proposal is to use STRIVE and RUG data, both are significantly outdated sources of information. Also, the RUG process will be sunset given CMS's change several years ago to PDPM. The risk adjustment methodology has not been reviewed by any body such as NQF nor TEPs to determine its accuracy and appropriateness. Therefore, we recommend not using this measure until its accuracy and risk adjustment has been tested and evaluated.

VIII B.3c. (5) Proposal to adopt total nursing hours per resident data (HPRD). Denominator.

This measure includes staff and residents from all payors and in the facility for any reason, including long stay residents. SNFs that have larger proportion of populations, more long stay residents, will have worse performance on this measure. The purpose of this measure is to be used in SNF VBP Medicare Part A program but captures information for the entire facility including MA plan beneficiaries, private pay and Medicaid beneficiaries.

VIII C.2 Proposal to revise the baseline Period for FY 2025.

We support the change to use FY2019 as the baseline period for the FY2025 program give the rationale outlined in the proposed rule.

VIII C.3.a Proposed Performance periods and baseline periods for SNF HAI

We support the proposal to adopt a 1 year performance period for the SNF HAI measure and to use FY2024 as the performance period should CMS proceed with the use of this measure. We still believe this measure requires further testing before being adopted into the SNF VBP program.

VIII C.3.b Proposed baseline periods for SNF HAI for FY 2026 and subsequent years

We support the proposal to adopt a q year baseline period and us FY2022 as the baseline period for FY 2026 program.

VIII C.4 Proposed performance periods for nursing HPRD in FY2026

If this measure is to be used, we support a 1 year performance period for the FY2026 program. However, we do not support the proposed FY2024 as the performance period. The data for this measure is collected and publicly reported quarterly starting 45 days after the end of the quarter. The staffing HPRD are released within another 45-60 days. As such given the CMS requirement to specify 60 days before the FY, its can easily use data from January 1st through Dec 31st (CY) and have the measure window closure in proximity to the program implementation. While alignment is often nice, alignment for alignment sake does not justify aligning the measure on FY nor trying to align with other claims measures. We do support using the data from 2 prior years as the baseline so that FY2022 will serve as the baseline period for FY 2026 program.

VIII C.5.a Proposed performance periods for DTC PAC measure for FY2027

We support aligning with the reporting period for the SNF QRP and to use FY2024 through FY2025 as the performance period for FY 2027 program period.

VIII C.5.b Proposed baseline periods for DTC PAC measure for FY2027

We support a 1 year baseline period and a baseline period being 2 fiscal years prior to the performance period. However, how will CMS take into consideration minimum staffing standards that they are proposing in other parts of the rule?

VIII E.2 SNF VBP Performance Scoring: prospects special scoring policy for FY023

We support excluding SNFs that do not meet the minimum sample size in FY 2023 given the rationale provided.

VIII E.3a SNF VBP Performance Scoring: proposed case minimum and measure minimum policies - background

We support the proposal for SNFs to meet a minimum sample size of 25 cases for the measure to be included and 25 residents for the HPRD measure. We also support the proposed approach to require a minimum number of measures (2out of 3 in FY 2026 and 3 our of 4 in FY2027). Given these proposed changes, it makes sense to drop the current minimum LVA policy inf FY2023.

VIII E.3.b SNF VBP Performance Scoring: proposed case minimum for SNF RM measure.

We support the proposal for SNFs to meet a minimum sample size of 25 eligible stays for the SNF RM measure given the rational and evidence provided.

VIII E.3.c SNF VBP Performance Scoring: proposed case minimum for SNF HAI, DTC and nursing HPRD measure.

We support the proposal for SNFs to meet a minimum sample size of 25 eligible stays for the SNF HAI and DTC measure as well as 25 residents for the nursing HPRD measure, given the rational and evidence provided.

VIII E.3.d SNF VBP Performance Scoring: proposed measure minimum.

We also support the proposed approach to require a minimum number of measures (2out of 3 in FY 2026 and 3 our of 4 in FY2027). Given these proposed changes, it makes sense to drop the current minimum LVA policy inf FY2023.

VIII E.4 Proposed update to scoring policy without sufficient baseline period

We support the proposal to not award improvement points to SFN that has not met the minimum sample size for that measure but agree that achievement score should be awarded if the measure meets minimum sample size for the performance period.

VIII E.5 Proposed to remove the LVA policy starting in FY 2023

We support the proposal to remove the LVA policy starting in FY 2023.

VIII E.6b. Proposal to update the scoring methodology starting in FY 2026: measure level scoring update

The overall approach to assign 10 points per measure for achievement and 9 points for improvement and equally weight each measure makes sense. Using the 25th percentile from the baseline period as the lower benchmark for the achievement score makes sense. However, we disagree with using the mean of the top decile SNF's during the baseline period. The median of the top decile would equate to the top 5%, assuming the mean and median are equivalent which they are unlikely to be. For the DTC measure that higher is better the mean may be higher than the median. For measure that lower is better, then the mean may be less than the median. Either way this still sets a benchmark that only 5% of SNFs met and in no way is tied to clinically meaningful or achievable goals. This methodology will discriminate against large urban SNFs, particularly those that provide care to minorities. Smaller facilities are more able to achieve better scores on average than larger facilities since none of these measure can account for random variation and differences in resident acuity and events that may trigger hospitalizations, infections, or discharge to community. We also know that facilities with larger proportion of minorities do more poorly on all of four of the proposed measure. Thus, these facilities will rarely be able to achieve the maximum score. We would recommend setting the benchmark at 10th decile which is then presented to a clinical TEP to review and adjust to make it clinically relevant. Many have worried that the SNF VBP use of SNF RM could create a financial incentive to deny hospitalizations that are needed if the benchmark was too low. Using the 95th percentile rate (which is essentially what is proposed), it is likely that to achieve that level,

providers may need to deny care unless they are small and able to achieve it due to the randomness of the residents they admitted. At a minimum CMS should calculate the proposed benchmarks now and present them to clinical panel to seek opinion if the benchmarks may have an unintended effect on denying care or create a bias toward facilities with minorities, thereby exacerbating disparities.

VIII F. Proposal to adopt validation process starting FY 2023

We support the proposed approach to validate the SNF RM measure. The logic for the SNF RM measure should apply to the other two proposed claims measures. The nursing HPRD measure already has a validation program built into it and is based on audited payroll data. Its unclear why an additional validation process for the PBJ should be added on top of the existing validation process.

The HAI measure is based on hospital claims that are notoriously based on inaccurate diagnosis of infections. We would recommend that the HAI measure have a chart review process to verify that several of the HAI diagnoses meet CDC criteria for HAI (not just that the medical record records the diagnoses) [See CDC criteria for HAI infections in LTC populations: *Stone ND, Ashraf MS, Calder J, et al. Surveillance definitions of infections in long-term care facilities: revisiting the McGeer criteria. Infect Control Hosp Epidemiol. 2012;33(10):965-977. doi:10.1086/667743*.]. the common overdiagnosis in hospitals will create problems to SNFs in the VBP program and create an incentive to not hospitalize residents because they may be misdiagnosed with an HAI.

VIII G. Proposal for SNF value based incentive payments for FY 2023

We support the proposal to assign the same IMP for all SNFs in FY 2023. However, we argue that given this assignment and historical data, we believe CMS can return more than the 60% of the 2% withhold. The statute allows up to 70% to be returned. Its unclear why CMS will not increase to as close to 70% given the fiscal situation SNFs find themselves in as a result of covid with higher staffing costs, higher PPE costs and higher COVID testing costs. Otherwise this approach to assign the same IPM to all providers is understandable during the pandemic, not returning more of the 2% which is statutorily allowed does not make sense.

VIII I.1.a Requests for future SNF VBP expansion policies – adding staffing turnover

we do not support adding staffing turnover. This is a structural measure inconsistent with the purpose of VBP. Just because a measure is correlated with quality does not make it appropriate for a VBP program. VBP are designed to link payment to quality outcomes not structure or process measures, particularly if the outcomes can already be measured. The relationship of this measure to quality has been shown relative to the other measures in the VBP program or other outcome measures that CMS can easily add to the program. It makes sense for use in the five star program. In addition, this measure is a facility wide measure not a measure unique to post-acute care for Medicare FFS beneficiaries. As such, its unclear how different size and volume of post-acute care impacts this measure. This is a new measure that has not yet been added to fiver star and only recently publicly reported. The performance of the measure is yet unknown and has not

undergone NQF endorsement either. Preliminary data using PBJ data linked with facility demographic data shows that turnover is higher in SNFs with higher minority populations that also have poor financial resources. Including in VBP program could acerbate the financial situation since they would disproportionately perform worse and have cut in Medicare rates.

VIII I.1.b Requests for future SNF VBP expansion policies – adding NHSN measures

We would not support adding NHSN vaccination measures. Its unclear how the COVID-219 pandemic and eventual spread of Sars-CoV-2 will take over the coming years. While it may seem appealing currently to look at staff vaccination rates its unclear if they will be as relevant in the future. Also, CMS has a mandate in effect with the variation in vaccination rates due to religious and medical exemptions which are legally allowed and can't be questioned per DOL ruling. Also the purpose of VBP is to link payment with patient outcomes and this is not a patient outcome measure. CMS also has other mechanisms to create incentives to increase vaccination rates including publicly reporting rates in five star. The frequency of boosters and what constitutes "vaccination course" is unknown and likely to change continuously as the virus continues to develop new mutations. As such, it may be challenging to figure out a measure period to use in a VBP program.

VIII I.1.c Requests for future SNF VBP expansion policies – updating the exchange function

We supported the rationale for using the logistic function when there is only one measure. The logic for the selection of that approach has not changed and any change should be consistent with the rationale for using the logistic function. The logic of a simpler to display and describe function (e.g. linear) does not make sense, as the method to determine a providers score to use in the logistic function is very complicated (it has to calculate either achievement or improvement for each measure, pick the higher of the two for each measure, add the scores together, normalize them and then use in the exchange function. The pros and cons of the different approaches should be evaluated for rewarding high performing SNFs and that does not create incentives at high end of performance to deny needed care to improve further.

VIII I.3. Requests comments on validation of SNF measures and assessment data

All the current proposed measures have a validation process already in place. The claims measures are validated by the carriers and the PBJ data has a validation process in place. The MDS data has been documented to be accurate in audits as cited. The MDS data also is commonly used by CMS surveyors to describe residents including their trips to the hospital. The citations for inaccurate MDS data are rare. The surveyors already look at the MDS data and its considered part of the medical record signed by the nurses with threats of punishment against their professional license. Its unclear if additional audits are required. Also, if chart review audits are undertaken, a process to determine how the MDS coding is equated with medical record review is necessary as some MDS items have different look back periods and averaging of resident's condition over that time period.

The proposal to use the hospital approach, where only 6% of hospitals have a validation by chart review or 6% a review of their electronic medical record. The CMS survey team already does a look behind validation survey of 5% of SNFs and could easily incorporate a review of the MDS during those validation surveys.

VIII I.3. Requests comments on measuring and improving health equity.

We would recommend that when CMS is evaluating the impact of their proposed measures and threshold for the VPB program that they incorporate an analysis on the impact it has on providers based on the demographic characteristics of the population they serve. The analyses reported in the proposed rule only report the impact proposals or measures have on overall national sample but should also be stratified by SNFs based on their racial and ethnic resident population. As we already mentioned in our comments several of the measures and some of the proposed policy changes will result in SNFs with higher populations of minorities being significantly disadvantaged.

Section VIII. Revising Requirements for Long-Term Care Facilities to Establish Minimum Staffing Levels

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

AHCA response: AHCA acknowledges that many staffing studies have been conducted over the years to consider a minimum staffing standard as noted by CMS in their proposal to request information; however, AHCA has seen that these studies are often limited to the correlation between number of staff and an area of quality and do not consider all of the elements that should be evaluated in the context of staff (education, competency, skill level/ years of experience, licensure, certifications, scope of practice, etc.) or quality (not definitively defined). There is an over-emphasis on the impact of staffing levels on quality. To date there is no evidence that establishes a one size fits all approach to minimum staffing requirements for both nurses and other direct care workers. There are many factors in addition to the conceptual idea of staffing by hours per resident day (HPRD) that must be considered (see comments on resident factors, facility factors and other factors under RFI question # 2) and there is not one study that conducts a holistic review considering all these combined factors. As mentioned, "quality of care" is not well defined and is limited in many studies to only specific areas (rehospitalizations, quality measures, five-star, adverse events, etc.).

Before any requirement is put into place that requires more staffing in skilled nursing homes, CMS should:

- Do more research on the relationship of auditable PBJ staffing with overall quality, not just individual measures.
- Look at staffing levels that take into consideration alternate payment models.
- Secure sustained financing through Medicaid and Medicare that supports improved staffing levels.

AHCA believes older studies remain relevant only to the extent that the research can still be duplicated using the past variables in a current study and yield the same or comparable results. However, AHCA suggests that CMS can use past studies to evaluate gaps and limitations in existing research to determine where more research is required. For example, the study frequently cited for minimum staffing in nursing homes is over 20 years old. The Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes 2001 Report was based on CMS 671 form data on staffing which is no longer in use due to the improved, and now auditable, staffing data collection via CMS Payroll-based Journal (PBJ), but even utilizing PBJ data has limitations because it does not fully capture all staffing hours due to caps placed on salaried positions (which includes nurses). In addition, the study analyzes aspects of care in nursing homes, many of which have changed since 2001.

In 2016, CMS Reform of Requirements of Participation went into effect which included the most comprehensive regulatory changes for nursing homes in over 25 years. These revisions included expanded requirements for comprehensive, person-centered care and numerous staffing related changes designed to reflect and better meet the needs of the changing nursing home population. The regulations also include changes to behavioral health services and staff with behavioral health and trauma-informed care competencies; enhanced requirements for food and nutrition services and related staffing capacity and competencies including new certifications; a facility assessment that enhances how facilities link staffing capacity and competencies with their unique resident population; a new requirement for an infection preventionist; enhanced training requirements for all staff targeted to the needs of the specific resident population; and expanded requirements in core areas of care and services as well as QAPI, all of which impact staffing.

In efforts to answer CMS's question, "*What are the benefits of adequate staffing in LTC facilities to residents and quality of care*,". Currently, CMS requires LTC facilities to have "sufficient nursing staff with appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment". CMS currently determines "sufficient nursing staff" through the survey process and compliance with F725. In 2020 and 2021, based on CMS's current process for determining "sufficient nursing staff," more than 95% of facilities were meeting the requirements according to QCOR data as evidenced by compliance with F725. [1]

The Institute of Medicine has defined quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge".[2] Both the determination of "sufficient nursing staff" (adequate) and "quality of care" need to be supported by holistic and realistic approaches informed by research that does not limit a facility from adapting to changing resident needs. Thus, to maximize the benefit of adequate staffing in LTC facilities to residents, flexibility must be afforded that allows for the facility to innovate and redesign as ongoing learning occurs about what is most helpful to advance quality of care.

[1] Quality, Certification & Oversight Reports (QCOR). (2022). *Deficiency reports: Citation frequency*. Retrieved from: https://qcor.cms.gov/main.jsp.

[2] Institute of Medicine. (1990). Medicare: A strategy for quality assurance. Volumes I and II. Lohr, K.N., ed. Washington, D.C.: National Academy Press.

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

AHCA response: AHCA believes there are at least three categories that CMS should consider if establishing a minimum staffing requirement for nursing homes: resident factors, facility factors, and other factors not related specifically to the resident or facility. All three components comprise a holistic view of areas that should not be left out of consideration when CMS considers a minimum staffing standard as they impact how a facility currently determines staff according to needs and resources.

a. **Resident factors**- including but not limited to, resident diagnosis, acuity and fluctuation of acuity, case mix index (considering this is a snapshot in time and may vary day-to-day), Brief Interview for Mental Status (BIMS) scores, section E of MDS behaviors impacting others (E0100 – E1000), safety needs (at risk for falls, at risk for elopement, etc.), activities of daily living (ADL) needs (hygiene and incontinence needs), length of stay (short term rehabilitation), clinical and psychosocial needs, nutritional needs, behavioral health needs, cognitive status, average number of medications per resident, preferences and demand (can be labor intensive even on lower acuity residents), high care needs of residents (TPN, dialysis, tracheostomy care, enteral feeding, complex wound management, intravenous therapy, infectious disease management, bariatric care) and care plan needs, and support required to carry out care.
b. **Facility factors**-including but not limited to, staff proficiency (competency, skill set, certifications, scope of practice), facility size and layout (to include multiple floors, dining space, nursing stations, resident room configurations and specialty units-ventilator, dementia, psychiatric, therapy-high acuity unit), other disciplines that provide care and support outside of nursing (PT, OT, ST, Psych, Social workers, clinical providers-MD, PA, NP, feeding assistants, activity staff, housekeeping, food & nutrition services, hospice, administrative staff, respiratory therapy, staff educators), use of technology (electronic medical records, telehealth, advanced call light systems, activity systems, nurse robots, etc.), location of facility (rural, urban, metropolitan), family or volunteer involvement, facility licensure type (Medicaid only vs. Medicare/Medicaid), consideration from the facility assessment, number of admission and discharges, needs at different times (night vs. day shift), evacuation and fire safety elements, on-call support, community support/resources (proximity to police, fire, ambulance services, hospital), staffing models (assignments, team nursing).
c. **Other factors**-including but not limited to, the ability to fund the staffing requirements at a federal and state level, availability of labor force to meet the need now and in the future, current staffing shortages, concerns hiring post pandemic because of perception and experiences that are expected to have an extended impact for years to come, the ability to afford offering competitive wages, existing staffing star ratings showing difficulty to meet current requirements or higher threshold goals in certain geographic locations, availability of support to train and educate staff (reimbursement options, colleges, certified nurse aide (CNA) training and testing centers), limited numbers of facility nurse aid training programs (Nurse aide training competency and evaluation programs (NATCEP) bans, lengthy/costly implementation process, stringent state

instructor requirements), agency rates, and ability to fully capture resident acuity due to limited resources and Minimum Data Set (MDS) limitations.

AHCA recommends that CMS consider the facility assessment as the primary component that helps a facility determine their staffing, and not establish a general minimum staffing requirement that will drive unintended consequences. The facility assessment was designed to allow the facility to determine what resources are necessary to care for its residents during both day-to-day operations and emergencies (Federal Registry, 2016). While the facility assessment is not an all-inclusive tool, it has served successfully (evidence of low "sufficient nursing staffing" citations) as an instrument to assist facilities in defining their resident acuity as well as additional factors needed to consider the holistic needs of the population each facility serves.

Acuity can change daily; residents can become acutely ill and their physical and mental changes can vary from shift to shift and moment to moment. Facilities should be able to have flexibility to be responsive to acuity and assign staff accordingly using their facility assessment as the starting point. It is important to recognize that no two facilities are exactly alike nor are any two residents the same. While there is a common perception that residents with higher acuity should equal more staff and those with lower acuity should equal less staff, this may not be the case for all facilities and residents and the type of staff needed can widely vary. Higher acuity does not always represent a need for an increase in the number of staff, it may represent a need for staff with a higher skill level, just as a lower acuity of residents does not necessarily mean that these residents do not have other concerns that require increased staffing needs. Resident needs vary from one resident to another, while one resident may require more care and services of a nursing assistant (resident with high ADL needs), another might require more care from a nurse or respiratory therapist (ex: resident on a ventilator). Merely assigning a ratio or hours per resident day (HPRD) minimum could result in unintended consequences of:

- Under staffing or over staffing to meet a requirement versus meeting residents' needs according to what a facility has outlined in their facility assessment.
- Devaluing the facility assessment or creating conflict between the unique facility assessment and the generalized minimum staffing requirement.

3. **CMS asks:** *Is there evidence of the actual cost of implementing recommended thresholds, that accounts for current staffing levels as well as projected savings from reduced hospitalizations and other adverse events?*

AHCA response: According to a study published by the Journal of the American Geriatrics Society, it was estimated in 2019 to cost skilled nursing facilities (SNFs) nationwide $7.25 billion annually to increase staffing to a proposed minimum of 4.1 HPRD as shown by position in the below grid. [3]

[3] Hawk, T., White, E.M., Bishnoi, C., Schwartz, L.B., Baier, R.R., & Gifford, D.R. (2022). Facility characteristics and costs associated with meeting proposed minimum staffing levels in skilled nursing facilities. Journal of the American Geriatrics Society, 1-10. doi:10.1111/jgs.17678

	HPRD Thresholds to Achieve	**Number of FTEs needed to reach thresholds**	**Annual Cost** (Not including payroll tax or fringe benefits)	**Percentage of SNFs that currently meet thresholds**
RNs	0.75	35,804	$3,836,084,692	31%
LPNs	0.54	3,509	$237,546,742	84.5%
CNAs	2.81	116,292	$5,124,691,043	10.7%
Total	4.1		$7,247,628,882	25% (5% meet all of the categories above)

Note: This does include a reduction in existing LPN salary cost to account for hours now covered by RN (LPN-RN Substitution) (- $1,950,693,595 annual reduction).

Because staffing is necessary but not sufficient alone in reducing hospitalization and other adverse events, it is challenging to quantify any projected savings from improved quality related to increased staffing. Staff training, organizational culture, facility systems and processes, and facility and community resources are some of the additional factors that impact quality alongside number or type of staff.

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

AHCA response: AHCA recommends CMS consider the following areas that require both staffing and financial resources that are not necessary to quality of patient care:

- Tasks that were initiated in the early days of the pandemic are no longer warranted, including screening and cumulative tracking and notifications per regulation at F885 which is duplicative of regulation at F580.
- Use of personal protective equipment (PPE) (face shield/goggles and N95 masks) beyond what is required based on evidenced based research, prevalence in community and creates a medical environment that deters from resident quality of life in their "home" as well as deters healthcare workers from the LTC setting as they can work in other parts of healthcare without using this extent of PPE at all times.
- Administrative demands related to unnecessary data collection as required with F884-NHSN reporting.
- Excessive COVID-19 testing for staff who are "fully vaccinated", but "not up to date" as required by regulation at F886.
- Administrative duties required to keep up with the frequent changes and requirements of CMS and CDC related to required policy developments and training/education.
- Enforcement approaches by CMS that are not consistent with statutory intent including per QCOR there were $16 million of CMP fines nationally to facilities for F884, the overwhelming majority of those as momentary lapses that were results of technical issues and corrected.
- Agency costs are excessive and a result of staffing agency price gouging consuming facility resources at two to four times the typical cost for staff.

- Excessive citations from surveys where a facility is cited for multiple F-tags for the same incident leading to the facility processing extensive paperwork and duplicative plans of correction, leading to escalation of CMP fines and loss of NATCEP programs
- Lack of advanced technology available in the facility due to limited financial resources and lack of funding supports for securing such technology that could improve delivery of care and services in a more efficient and effective manner.

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

AHCA response: AHCA recognizes there are many factors impacting a facility's capability to successfully recruit and retain nursing staff. One of the biggest obstacles is the shortage of staff available. Facilities are currently facing substantial workforce shortages and these staffing challenges are likely to increase in the US: projections show the country will require an additional 3.5 million long-term care health workers by 2030 to maintain current staff–to–care recipient ratios.[4] The COVID pandemic has also exacerbated the workforce challenge with long term care industry currently at a 15-year low in number of employees with over 406,000 jobs lost since February 2020.[5] CMS will need to consider how providers will even logistically be able to meet a new federally mandated staffing minimum standard amid a national healthcare shortage that is projected to get worse. Without adequate supply of workers, such a mandate will create major unintended consequences including escalating access to care issues.

Providers are exhausting their efforts to recruit and retain workers. It remains one of the top priorities for nursing homes. Some examples of efforts providers are making include, but are not limited to, sign-on bonuses, wage increases, bonuses when someone fills a shift, scholarships, day care options, mentorship programs, promotion of culture and teamwork, calling staff who have left to encourage them to come back, referral bonuses paid to staff for each employee they recruit, gift cards, discount programs, career ladders, providing free meals to staff, using agency staff to supplement (which comes with its own challenges as noted below), tuition reimbursement, enhanced PTO, flexible scheduling and providing staff training and education.

[4] Institute of Medicine. (2008). *Retooling for an aging America: Building the health care workforce*. Washington, DC: National Academies Press.

[5] American Health Care Association (AHCA). (2022). BLS March 2022 jobs report. Retrieved from: https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/BLS-MARCH2022-JOBS-REPORT.pdf

Organizations such as AHCA/NCAL are also working on multiple fronts to attract and retain workers including outreach to prominent refugee organizations and migrant farm workers noting that facilities are ready and have open availability with a variety of positions for refugees that would like to work in them. In addition, AHCA/NCAL also has a partnership with Equus on apprenticeship program support to encourage more to get into the LTC field. Finally, AHCA/NCAL will be holding their first ever Workforce Summit at their national convention Fall of 2022 to discuss several key workforce topics amongst providers from across the country, including focusing on creative strategies and issues around provider recruitment and retention issues. Even with these dedicated efforts, the workforce crisis is still growing in the LTC sector, and it is apparent that improvement will not be seen or sustained unless there is a nationwide effort and support for the sector.

The availability of funds is another large impact on the facilities' ability to recruit and retain nursing staff. According to Hawk (2022), nursing homes will need government resources to attract and retain staff in order meet potential new quotas. This study found that nursing homes need another $7 billion a year to hire more than 150,000 new caregivers.[6] Since their revenue is fixed by government reimbursement rates, nursing homes cannot create these jobs on their own. Labor costs are skyrocketing as facilities continue to weather the pandemic in their buildings. In a survey conducted by AHCA/NCAL, projected 2022 contract labor costs are expected to increase on average by 106% for sample of 752 buildings. Extrapolating this calculation results in $131,000 per building in new, projected FY22 contract labor costs, nationally, in addition to double digit in-house labor costs of on average 18% nationally.

AHCA/NCAL is also hearing countless examples of direct care staffing agencies charging supercompetitive prices to desperate LTC centers that simply need workers. In fact, AHCA/NCAL has heard directly from several state affiliates of efforts in which they are trying for legislative fixes to prevent these agencies from charging double to quadruple plus of what operators pay their staff. The staffing agency worker makes only a fraction of what the agency is charging the provider for that worker. Providers have little choice but to pay exorbitant prices, and hope that the agency does not poach their staff once in the building. Most LTC centers are paid through the Medicare and Medicaid programs – and thus, taxpayer dollars. These staffing agency prices are simply not sustainable for providers and the current reimbursement system structure. Money being spent should instead be going towards other needed resources that are resident care focused. In addition, the regulatory framework of the state and local government, its workforce programs, as well as the facility’s geographic location in terms of urban or rural settings all have an impact on nursing staffing.

[6] Hawk, T., White, E.M., Bishnoi, C., Schwartz, L.B., Baier, R.R., & Gifford, D.R. (2022). Facility characteristics and costs associated with meeting proposed minimum staffing levels in skilled nursing facilities. Journal of the American Geriatrics Society, 1-10. doi:10.1111/jgs.17678

In addition, criticism from the local, state, or federal governments of the LTC sector deters individuals from wanting to work in LTC and devalues the individuals who are currently working in LTC today, driving them to other parts of the healthcare sector that are seen as valued. Government agencies and other stakeholders need to be part of the efforts to help this sector recover, to stabilize the workforce and to rebuild for the future. This means prioritizing LTC for supports and resources, providing relief from requirements that do not drive improved care and being responsive to the changing environment that providers are facing every day and giving their all to overcome the enormous challenges.

Some of the risks facilities face in implementing workforce strategies include adequate reimbursement as noted above, finding qualified candidates, staffing agency concerns as also noted above, staff time availability for mentoring or being a preceptor, and concerns of excess survey scrutiny. Meaningful investment must occur in the sector to provide hope for recovery and to allow for care improvements into the future that our nation's seniors deserve. CMS should consider updating the Market Basket in two ways: 1) a one-time update account for below labor costs updates over several years; and 2) a new approach to calculating the labor portion of the Market Basket. See **Section II** for more details on AHCA's proposed Market Basket update approach.

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

AHCA response: AHCA recommends CMS establish a process and criteria by which facilities can apply for an exemption or waiver through the state agency if they have circumstances that prevent them from obtaining adequate staffing. Furthermore, CMS should consider "good faith effort" as a range of ways facilities can demonstrate including attempts through documented efforts to recruit and retain, develop staff. CMS should not be prescriptive in what those efforts must entail as approaches will need to vary by region, market, community and adapt based on efforts the facility has already tried or new opportunities that arise. CMS should provide clear direction to surveyors on recognizing "good faith efforts" to bring consistency to the survey process and prevent surveyors making independent "subjective" determinations of "good faith efforts."

Good faith effort attempts by facilities may include but are not limited to the following: staff focused on recruiting efforts, various avenues of advertising/job postings, number of applicants, number of interviews held and/or job offers, evidence of competitive wages and/or benefits, existing financial barriers and attempts to overcome barriers, incentives and/or actions taken to entice applicants, outreach to community partners or stakeholders, retention efforts for current staff, other actions taken by the facility in effort to meet the requirement. CMS should also consider establishing a criterion for determining who may be considered exempt from the staffing requirement (i.e., smaller facilities, rural facilities, those with limited availability of licensed staff within commuting distance, etc.). CMS should allow alternative options when a facility is not able to meet the requirement but is making other efforts (i.e., RN on call, telehealth, reassignment of staff in the facility to help with needed duties). CMS should

not cite a deficiency when "good faith efforts" are present. In addition, when a facility shows through "good faith effort" attempts that they have exhausted their resources to recruit staff, CMS should assist states in providing support for facilities (such as seen with strike teams).

AHCA believes CMS will have a difficult time accounting for job quality, pay and benefits, and labor protections without an objective process in place. CMS would need to consider current facility metrics (turnover, retention, satisfaction, pay-market rate/benefits, union contracts, etc.) in addition to recruitment factors (location, availability of qualified personnel, number of candidates, competition, etc.) and impact of any state or local requirements to look holistically at the providers' attempt to make good faith efforts to recruit staff but should not dictate an exhaustive list because interventions by facilities will need to change over time and new approaches will be learned as time goes on. While pay/benefits are one area that CMS has addressed in the question of assessing "good faith efforts," AHCA believes that CMS can review this as an area the facility addresses as a "good faith effort" but CMS should not direct or determine what pay is appropriate for staff since there is such variation across the country, among employee skills sets and facility work design. Also, pay and benefits is not an area CMS examines for any other entities in which they govern so it should not be an area they have authority over for nursing homes.

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

AHCA response: Nursing staff turnover may be considered one of many potential components that help determine quality. Evidence shows that staffing levels are not the only indication of quality in nursing homes, and that other staffing measures, such as turnover, retention and agency use must be considered. [7] Nick Castle, Professor at the University of Pittsburgh has produced two studies on this topic, the first, Staff Turnover and Quality of Care in Nursing Homes, shows that both staffing levels and turnover are independent predictors of quality, and that turnover is a slightly stronger predictor. [7] In the second, Turnover Impact on Quality Measures, a similar analysis again suggests turnover has a stronger association with each quality measure rather than staffing levels. [8]

[7] Castle, N.G. & Engberg, J. (2005). Staff turnover and quality of care in nursing homes. Med Care, 43(6):212-626. doi: 10.1097/01.mlr.0000163661.67170.b9.

[8] Castle, N.G., Engberg, J. &Men, A. (2007). Nursing home staff turnover: Impact on nursing home compare quality measures. Gerontologist. 47(5):650-651. doi: 10.1093/geront/47.5.650.

While acknowledging that turnover may be a potential component that requires further research, AHCA asks CMS to recognize there could be a variety of reasons as to why an employee leaves a nursing home that could be completely out of the control of the facility and should not be factored into establishing a standard. The pandemic intensified an already strained LTC workforce. Exacerbated by the pandemic LTC facilities are facing a historic labor crisis, losing more than 406,000 caregivers since the beginning of the pandemic, and workforce levels are at a 15-year low. HHS' Assistant Secretary for Evaluation and Planning produced a report which discusses the disproportionate impact of the workforce crisis on nursing homes.[1] This will take time to recover from. Staff might leave a center due to childcare obligations or better pay at a competing health care center or grocery store. Burnout and being concerned about COVID are other reasons staff have left. Research is showing a new phenomenon of long social distancing in some parts of the workforce that is driving individuals away from jobs that require onsite work such as healthcare to jobs that allow them to fully work from their home with the variety of factors here for leaving it makes it incredibly challenging to factor into establishing a standard. [2]

Regarding the use of short-term/agency nurses, facilities should not be penalized for using them (i.e., counted in turnover and retention measures). Short-term/agency nurses should be counted the same as regular staff in calculating staff hours since they are interim to supplement LTC staffing needs. CMS should refer to its existing requirement in the Payroll-Based Journal System and consider all staff, including contracted staff and agency staff, as part of the care team.

Due to the workforce crisis, providers simply have little choice but to hire temporary/agency staff and pay exorbitant prices, there are legislative efforts and laws in some states to prevent these agencies from charging double to quadruple plus of what operators pay their staff. The staffing agency worker makes only a fraction of what the agency is charging the provider for that worker. Use of agency staff is a reality in health care right now for some centers to remain in operation. In addition, today's workforce wants flexibility, which is an attractive feature of staffing agency work. They can choose when and how often to work like Uber drivers. These appealing options and higher than average pay rates have pulled staff away from facilities and continue to exacerbate the crisis for facilities.

8. **CMS asks:** *What fields and professions should be considered to count towards a minimum staffing requirement? Should RNs, LPNs/LVAs, and CNAs be grouped together under a single nursing care expectation? How or when should they be separated out? Should mental health workers be counted as direct care staff?*

AHCA response: AHCA recommends CMS take a comprehensive approach to determining which staff types are included in the minimum staffing requirement. Non-nursing staff matters to resident care yet are not considered in current discussions around minimum staffing. To better address the resident needs, facilities are moving to staffing models that incorporate a diverse set of professionals, such as behavioral health specialists, social workers, infection preventionists, activity staff, respiratory therapist, and physical therapists. In addition, due to the staffing crisis, facilities are increasing their use of non-licensed staff to meet basic resident needs, such as answering call lights or delivering trays. These individuals can also play a key role in a residents' care and quality of life. It is important that CMS support the use of these professionals as they are key to assisting with the physical and mental well-being of the resident. A staffing model that focuses only on nursing staff is counter to guidance that centers must meet the comprehensive needs of the resident to ensure they attain or maintain their highest practicable level of function.

The Payroll-Based Journal System manual which contains the job descriptions is helpful in this regard, particularly the categories of nursing, dietary (food & nutrition services), therapeutic, and mental health. Examples of staff positions this could include are licensed nurses, CNAs, nursing assistants or student nurses (not certified), infection preventionist, environmental/hospitality aids, medication aids, feeding assistants, activity staff and assistants, behavioral health staff and aids, physical and occupational therapists and aids, respiratory therapists, and social workers. AHCA recommends any minimum staffing requirement supports the recognition of direct care staff as well as non-direct care staff who help meet residents' daily needs and support the goals of the care plan.

Many nursing homes are using types of staff to meet resident's needs that are not currently included in the CMS PBJ HRPD used in SNF's five-star ratings. An expanded definition of staff is needed in the staffing domain of the five-star rating to capture additional staff that are meeting residents' needs by providing care and services essential for quality of life.

- For example, SNFs with higher acuity often use respiratory or other therapists (e.g., PT, OT and SP) which are collected through PBJ but not incorporated in five-star staffing calculations.
- Feeding assistants are a category of specially trained staff shown to have a positive impact on quality but are also not included in the staffing rating for five-star.
- Some SNFs have also created a "hospitality aide" position as mentioned above (also known as bed aides, hall monitors, concierge directors, etc.) to provide direct care assistance for non-nursing related functions and free up licensed nursing staff to work at the top of their scope of practice.
- Models such as this provide two-folded benefit by meeting the needs of the residents and providing a career ladder to recruit and retain staff that are easier to find given the widespread shortage of licensed health care nurses (RNs, LPNs and CNAs) better and more efficiently.

On the question of grouping CNA's, LPN's, and RN's, AHCA recommends that non-licensed staff be grouped with licensed staff since the disciplines are working together to take care of the residents using an integrated approach. We recommend including each of the disciplines into a total as we do not agree that each discipline (licensed and non-licensed) should have separate thresholds, but CMS should consider allowing providers to meet a total threshold while allowing the provider to determine licensed and non-licensed thresholds based on acuity and residents' needs. Since facility population varies, the staff support needed to provide care and services varies as well and applying a one-size fits all threshold per discipline limits the flexibilities a facility may have in adjusting their staffing to meet the needs of the residents.

As stated above, AHCA believes it is vital that CMS recognizes the work of mental health professionals. As mental health diagnoses, substance abuse, PTSD, and even dementia is increasing in the nursing facility population, the need for specialized mental health workers is increasing. CMS must incentivize the use of licensed behavioral health staff. By recognizing nursing staff only, CMS is disincentivizing nursing homes from utilizing positions that meet all

the psychosocial needs of residents, another unintended consequence of a minimum staffing requirement.

9. **CMS asks:** *How should administrative nursing time be considered in establishing a staffing standard? Should a standard account for a minimum time for administrative nursing, in addition to direct care? If so, should it be separated out?*

AHCA response: Administrative nurses play a significant role in addressing the needs of residents and fulfill many regulatory required duties per CMS regulation. Standards of care that promote high quality care delivery and outcomes cannot be achieved without systematic education, training, oversight and evaluation, a key role of the administrative nurse. Administrative nurses typically serve a leadership capacity in a facility which has the impact across a large part if not all of the facility and are often the "glue" that keeps provision of care and services to residents together. They are also often involved in developing plans of care and/or the resident assessment, which requires patient-centered collaboration with family and residents and other healthcare providers. In addition, the role of the administrative nurse has changed drastically over the past two years and currently most administrative staff spend at least a portion of their day working on the floor and providing direct resident care. While this is not sustainable nor ideal for administrative nursing staff for extended periods of time, it is the only option for some providers amidst the workforce crisis. For example, many administrative nurses spend a sizable portion of their time assisting with tasks such as meals, answering call lights/resident requests, assessing residents, communicating with families, and managing infections. Therefore, staffing standard methodology must allow and account for this time. AHCA recognizes that this varies by building, and future trends in staffing models and patterns may further shift the role of the administrative nurse. As a result, AHCA recommends that CMS allow flexibility in capturing administrative nurse time within staffing standard requirements. In the event an administrative nurse does not have any duties that relate to resident care or services, then they could be excluded. This would be a rare circumstance based on how administrative nurse roles function in a facility.

AHCA does not support a minimum amount of time required for administrative nursing. The needs of a facility vary by size, population, and day-to-day needs. The decision for time spent on administrative vs. direct care nursing should be made based on facility assessment which is developed based on the unique needs of each facility, versus a one size fits all approach that will unintentionally exclude capturing important care and services for residents.

10. **CMS asks:** *What should a minimum staffing requirement look like, that is, how should it be measured? Should there be some combination of options? For example, options could include establishing minimum nurse HPRD, establishing minimum nurse to resident ratios, requiring that an RN be present in every facility either 24 hours a day or 16 hours a day, and requiring that an RN be on-call whenever an RN was not present in the*

facility. Should it include any non-nursing requirements? Is there data that supports a specific option?

a. **AHCA response:** AHCA does not believe enough reliable information exists to establish a minimum staffing requirement. AHCA recommends that CMS conduct a study true to minimum levels, considering type of facility (one size does not fit all). The study should be expanded to include 1) the cost of the recommended staffing levels proposed by CMS to determine adequate funding along with 2) availability of staff (current and projected looking forward) to meet levels to inform reasonable and appropriate implementation date which may need to be phased by state(s) and/or local communities based on supply of staff and current staffing levels as well as provision of adequate funding. 3) establish a steering committee with a balanced representation including providers that review the study plan, study results, implementation approach and supporting interventions. Workforce development support must be in place to support implementation, including the multiprong workforce approach outlined in AHCA's Care for Our Seniors Act Workforce proposal, addressing NATCEP ban statute revisions and supporting temporary nurse aide (TNA) to certified nurse aide (CNA) transitions. 4) flexibility allowances for various models of staffing and criteria for temporary waivers; and 3) consideration of resident population variations such as care of people with dementia or behavioral health focus facility. CMS also should allow reasonable time post study completion to engage stakeholders in review and feedback of study findings to inform any requirements that follow. In addition, based on feedback from nursing home providers, many of whom already have minimum staffing requirements in their state, if CMS requires a minimum staffing standard based on HPRD there are several factors that CMS should consider. First, there should be an acuity adjustment to tailor the requirement to each unique facility and its resident needs. Second, it should consider quality and other patient outcomes, such as customer satisfaction. If a facility is achieving high outcomes on clinical, quality of life and other resident focused measures, it should not be penalized for not meeting minimum staffing requirements, as doing so can create unintended consequences of disrupting reliable facility systems and processes that are delivering positive outcomes for residents. It should be flexible and accommodate the changing environment of a nursing home. Finally, there should be accommodations for rural nursing homes, especially for allowing telehealth or remote available presence versus requiring a RN in the building.

b. AHCA also asks CMS to consider the responses CMS has given in the recent past related to minimum staffing recommendations. In 2016, as outlined in the Medicare and Medicaid Program; Reform of Requirements for Long-Term Care Facilities, CMS responded to comments regarding the implementation of minimum staffing requirements with concern that mandated ratios could result in unintended consequences such as staffing to the minimum, input substitution (hiring for one position by eliminating another), and task diversion (assigning non-standard tasks to a position), as well as stifling innovation, and would not result in the improved quality and person-centered care that CMS seeks in facilities. CMS commented that they continued to have concerns about establishing appropriate minimum standards and concerns that facilities would justify

staffing to the minimum standard even when more are required in the context of a competency-based approach. As discussed in the preamble to the proposed rule, CMS identified that mandating a minimum staffing requirement is a complex issue and they do not agree that a "one size fits all" approach is best. CMS stated they do not necessarily find that the 4.1 hours per resident day (HPRD) is the right standard for every facility. CMS further provided elaboration on their rationale and intent:

- LTC facilities are varied in structure and in their resident populations. Some facilities are Medicare-only SNFs that focus on short term rehabilitation services. Others are primarily Medicaid facilities that include primarily long-stay residents. Many are both. Some facilities specialize in dementia care. Some facilities have pediatric residents, young adult residents, or ventilator dependent residents.
- The care needs of each of these populations are different. Facilities range in size from the small to the large.
- The capabilities of these facilities are likely to be different. Our intent is to require facilities to make thoughtful, informed staffing plans and decisions that are focused on meeting resident needs, including maintaining or improving resident function and quality of life.

c. CMS also stated that they would consider a phased-in approach if they determine to impose minimum staffing standards through future rulemaking.

11. CMS asks: *How should any new quantitative direct care staffing requirement interact with existing qualitative staffing requirements? We currently require that facilities have "sufficient nursing staff" based on a facility assessment and patient needs, including but not limited to the number of residents, resident acuity, range of diagnoses, and the content of care plans. CMS welcomes comments on how facilities have implemented this qualitative requirement, including both successes and challenges and if or how this standard should work concurrently with a minimum staffing requirement. CMS welcomes comments on how State laws limiting or otherwise restricting overtime for health care workers would interact with minimum staffing requirements.*

AHCA response: AHCA believes that it is important for any staffing requirement to recognize the variability that exists in the types of care and the individuals served within nursing care centers. A staff requirement must not simply be set to a minimum number but must allow for flexibility and adaptability considering changes in resident acuity and case mix index. Furthermore, there needs to be recognition that non-nursing staff are an imperative part of the care provided. The care provided by physical therapists, respiratory therapists, speech language pathologists, etc. must be considered based on the needs of the residents.

Currently, providers utilize the facility assessment, care plans, and therapy assessments to determine staffing needs. Implementing a minimum staffing requirement would negate the value and purpose of the facility assessment. In fact, CMS initiated the requirement for a facility assessment as an alternative to a minimum staffing requirement. If CMS was to implement a minimum staffing requirement, then the facility assessment requirement should be discontinued. However, we want to express the value of the

facility assessment and recommend CMS maintain focus on that requirement versus implementing another staffing requirement.

There is variability amongst states when it comes to overtime with some states not having any restrictions on the number of overtime hours and others like Colorado having specific restrictions. In Colorado, there is a daily overtime threshold of 12 hours per day in addition to the standard weekly threshold of 40 hours per week. A special overtime threshold of 80 hours per 14 days applies to hospital and nursing home employees. Imposing a restriction on overtime could negatively impact facilities who are experiencing significant staffing shortages and result in their inability to meet a set minimum staffing standard.

Under the current Payroll Based Journal (PBJ) standards, for exempt staff who work additional hours (pick up additional shifts), it is not feasible to report these unless a payment is made that directly correlated to the hours worked and must be distinguishable from other payments. This policy decision impacts the accuracy of hours for nearly all exempt employee job classifications unless providers provide an additional bonus payment, which are not the norm and raise questions with DOL laws about exempt vs non-exempt status, particularly the statement that the bonus must be reasonable compensation. This policy results in many exempt employees who provide patient care (e.g., nurses) being unable to count any hours over a typical 35-40 hours worked in a week. For example, when a nurse covers an extra shift on the weekend (a common occurrence), stays late, covers for a colleague who calls in sick and works more than the total hours of a typical work week (a common occurrence in healthcare settings providing 24 x 7 care) the hours of care provided by the employee will be calculated as 35 or 40 hours rather than the actual hours worked providing care. This problem also manifests itself in administrative job positions. For example, in many SNFs/NFs, directors of nursing or nursing home administrators who are also nurses, frequently provide care to residents when shifts are uncovered. They also may help when care needs are particularly busy on a unit or more often cover shifts when staff call out sick, or during emergencies. This is more frequent in rural and small SNFs/NFs and on weekends and happens in nearly all nursing homes. These hours are often in addition to their normal work-week hours. However, CMS's decision to only consider hours paid for exempt employees in administrative rolls results in significant inaccurate information for RN and total nursing staffing hours per resident per day.

CMS should allow SNFs/NFs to report hours worked for exempt employees using data from time and attendance record keeping, which are auditable by survey inspectors. In fact, the hours submitted to CMS currently under PBJ come from the time and attendance systems and the time and attendance systems used by CMS auditors as well as DOL when auditing workers hours worked. In addition, §483.30(e) requires all SNFs/NFs to post daily and retain for 18 months, the daily hours worked by registered and licensed nurses and certified nurse aides for every shift. CMS will cite and fine SNFs/NFs that do not comply with this statutory record- keeping requirement. Many providers have swipe card time and attendance record keeping that can be used to accurately collect data on hours worked by each exempt employee. Allowing SNFs to use hours worked from either of these systems will improve the accuracy of the data collected by CMS. We recommend allowing these hours worked to provide resident care to be included in the PBJ system as long as the facility has a record, or the hours worked consistent with current requirements or DOL standards.

12. **CMS asks:** *Have minimum staffing requirements been effective at the State level? What were facilities' experiences transitioning to these requirements? CMS would welcome comments on experiences with State minimum staffing requirements.*

AHCA response: The LTC workforce crisis is a problem across states that do or do not have minimum staffing requirements. No state which has such a minimum staffing requirement can be said to have reached perfection with staffing. Nursing homes are simply struggling to find qualified staff. State workforce needs in SNFs can vary across the country based on a variety of factors, including federal and state funding support and policies. A study conducted by Mueller (2006), titled Nursing Home Staffing Standards, looked at minimum staffing level requirements in states and supported the fact that acuity and Medicaid were more important predictors of staffing levels. [9]

It is important to note that AHCA released a long-term care reform proposal last year (Care for Our Seniors Act), which supports the following positions if fully funded and the workforce is available:

- Enhanced Infection Control Preventionist: Effective infection prevention and control practices in nursing homes provide a safer, healthier environment for residents and improve quality of life. AHCA is willing to help establish an updated guideline for staffing infection preventionists for nursing homes based on proven, successful strategies. This includes proper funding and workforce availability to effectively implement meaningful, sustained changes.
- 24-Hour Registered Nurse (RN): Research shows a positive association between RN hours and overall quality. We support a new federal requirement that each nursing home have a RN on-staff 24 hours a day and will provide recommendations on how to effectively implement this requirement.

[9] Mueller, C., Arling, G., Kane, R., Bershadsky, J., Holland, D., & Joy, A. (2006). Nursing home staffing standards: Their relationship to nurse staffing levels. Gerontologist, 46(1):74-80. doi: 10.1093/geront/46.1.74.

Finally, some of AHCA's state affiliates that do have a minimum staffing requirement in place would welcome sharing their experiences with CMS. AHCA would be happy to coordinate such a meeting. One such affiliate is our Florida affiliate. In its 2022 legislative session, Florida modified the state minimum staffing requirements to add needed flexibility by recognizing all the direct care being provided by staff other than nurses and certified nurse assistants. In promoting the person-centered model of care, Florida facilities can now staff to the level of care and services needed as reflected in each resident's plan of care, while at same time, allowing for holistic care and promoting innovation. Traditionally, Florida's facilities have received high star ratings on staffing and quality care. Florida felt their approach of incorporating more of the person-

centered care concept by recognizing the contribution of direct care staff other than nurses is appropriate to the current and future needs of residents.

AHCA recommends CMS prioritize supportive efforts to help nursing homes build their workforce first (before pursuing any further minimum staffing requirements), and in future years when data is available explore how innovative staffing models and approaches such as Florida's impact delivery of care which can inform broader efforts CMS can engage in.

13. **CMS asks:** *Are any of the existing State approaches particularly successful? Should CMS consider adopting one of the existing successful State approaches or specific parts of successful State approaches? Are there other approaches to consider in determining adequate direct care staffing? CMS invites information regarding research on these approaches which indicate an association of a particular approach or approaches and the quality of care and/or quality of life outcomes experienced by resident, as well as any efficiencies that might be realized through such approaches.*

AHCA response: As noted above, some state affiliates that do have a minimum staffing requirement in place would welcome sharing their experiences with CMS. AHCA would suggest that CMS study whether/how these standards have impacted quality. It is also important for AHCA to mention that states often require certain staffing levels but do not provide adequate funding due to their specific allowable cost cap which impacts the facility's ability to meet these requirements. With that said, below are a few successful workforce support policies and ideas that some AHCA state affiliates have advocated for or done:

- Workforce summit to bring together a variety of LTC stakeholders and policy makers to have conversations on addressing the workforce crisis.
- Successful refugee support partnerships where our new neighbors can begin a career in LTC.
- Tuition free CNA training and apprenticeship programs to get more engaged in the field.
- State appropriation for Medicaid provider rates for an increase in funding for nursing facility providers.

State supported funds to recruit, train and place CNAs and caregivers in LTC centers.

14. **CMS asks:** *Should CMS concurrently require the presence of an RN 24 hours a day 7 days a week? CMS also invites comment on the costs and benefits of a mandatory 24-hour RN presence, including savings from improved resident outcomes, as well as any unintended consequences of implementing this requirement.*

AHCA response: AHCA supports a new federal requirement that each nursing home have a RN on-staff 24 hours a day as outlined in our Care for Our Seniors Act when there is availability of RNs and with the financial support needed to meet this requirement. We recommend this as an enhanced staffing standard over the idea of a broader minimum staffing requirement because the evidence is stronger for impact on quality associated with higher RN staffing.

For such a requirement to be successful, it is imperative that certain regulatory flexibilities be considered, such as acknowledging the size and location of nursing homes, workforce availability, advancements in technology, and more. Specifically, we recommend:

- Providing flexibility to meet the requirement due to day-to-day issues that arise in a facility over 24-hour periods, such as during an emergency and if an RN is not available for all 24 hours
- Expanding the availability of waivers for:
    - Rural, small nursing homes
    - Nursing homes with severe workforce shortage situations
    - Nursing homes with resident populations that do not require or benefit from 24-hour RNs
- Allowing telehealth RNs to achieve this policy in times of RN shortage as well as rural areas and small nursing homes
- Counting actual time worked of all RNs (including management when they support care or services for residents), not just scheduled or paid time
- Including nurse practitioner hours (who are RNs) as hours to comply with this requirement
- Realistic phase-in period to consider workforce supply and availability

The implementation of a 24-hour RN requirement also requires that policy makers implement policies to increase the availability of nurses in long term care. Recommendations include:

a. Financial Incentives
    i. To RNs and students in RN training:
        1. Offer loan forgiveness for RNs who work in nursing homes and are recent graduates
        2. Create tax credits for RNs who work in nursing homes
        3. Provide grants to increase RN participation in nursing homes in Health Resources and Services Administration (HRSA) designated areas
    ii. To schools/universities and nursing homes:
        1. Increase subsidies and grants to nursing schools based on the number of graduates working in nursing homes for 2 years or more
        2. Federal grants for nursing homes and universities to establish formal partnerships that include:
            a. Tuition-paid scholarships beginning with first-year nursing students entering post-acute/long term care (or similar track)
            b. Partnership with nursing homes to employ nursing students as CNAs (no certification required)
            c. Developing or expanding existing “LPN to RN bridge program progression” run by nursing schools and colleges
            d. Provide funding to nursing homes that increase training opportunities for RNs, such as serving as clinical training sites for RN students

e. Provide grants to nursing homes to support a career ladder scholarship program that encourages lower-level staff to work their way to an RN position

b. National Campaign to Recruit RNs into Nursing Homes Funding to support a joint effort of the Centers for Medicare and Medicaid Services, the U.S. Department of Labor, HRSA, and states supported by professional nursing associations, colleges of nursing associations and nursing homes aimed at:
    i. Showing the value of nursing homes and calling to serve LTC populations
    ii. Highlighting the incentives available to RNs who pursue careers in nursing homes available to new graduates as well as experienced RNs
c. Level the Playing Field for RNs in Nursing Homes Align reporting of nurses to their licensing board for adverse events to be consistent in all settings. Currently, nurses involved in adverse events in nursing homes are treated differently than nurses involved in the same events in hospitals or home health.
d. Support State-Based Efforts
    i. Create and fund an emergency workforce, available from local and state sources, to deploy to nursing homes in need to maintain requirements
    ii. Discourage state laws that are inconsistent with 24-hour RN presence by linking certain federal funding to states only when they align with a staffing requirement of a 24-hour RN in nursing homes

15. **CMS asks:** *Are there unintended consequences we should consider in implementing a minimum staffing ratio? How could these be mitigated? How would a minimum staffing ratio impact and/or account for the development of innovative care options, particularly in smaller, more home-like settings, for a subset of residents who might benefit from and be appropriate for such a setting? Are there concerns about shifting non-nursing tasks to nursing staff in order to offset additions to nursing staff by reducing other categories of staff?*

AHCA response: Yes, there are always unintended consequences when using one-size fits all approach. For example, facilities often specialize in a particular type of care, such post-traumatic stress disorder, brain injuries due to substance abuse, ventilator units, or dementia units. All of these specializations result in a mix of residents that are younger and more mobile, needing less ADL care and more mental health services. So, creating prescriptive minimums without consideration of the vast differences in care needs incentivizes a system of staffing to the minimum standard instead of the resident's needs. Another example of unintended consequences may be learned from COVID-19, that isolation and human interaction is vital to health. Activities staff that engage and address the mental and emotional needs of residents are just as important as CNAs who assist with personal care needs. Therefore, discounting other direct care staff by just basing staffing requirements on the nurse category of staff disincentivizes person-centered care and devalues staff who are not counted in the minimum standard. This could also exacerbate the staffing crisis and further increase agency use, causing agencies to increase their prices even more, which will only serve to reduce the overall quality of care. Finally, the nursing shortage makes meeting a minimum requirement extremely difficult and the impact of enforcement could result in more closures of units or entire facilities. Therefore, AHCA/NCAL recommends CMS first focus on supportive efforts to help nursing homes build the workforce supply before pursuing a new staffing standard which must be informed by a comprehensive study and when the sector has recovered from COVID-19 impacts,

if such a minimum staffing requirement is pursued it should be designed with flexibility that honors good faith efforts and outcomes above stringently meeting requirements, to help mitigate unintended consequences.

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

AHCA response: Yes, due to the pandemic LTC facilities are facing a historic labor crisis, losing more than 406,000 caregivers since the beginning of the pandemic, and workforce levels are at a 15-year low. SNF communities are facing the worst job losses among all health care professions, and the shortage is impacting access to care for our nation's seniors and individuals with disabilities. More than half of nursing homes were limiting new admissions in recent months—at a time when overwhelmed hospitals needed assistance to free up precious beds due to the Omicron surge.

Unfortunately, there has been an unprecedented level of LTC centers shuttered across the country, with rural areas bearing the brunt of these closures. In fact, more than 300 nursing homes have closed over the course of the pandemic (2020-2022), mostly due to staffing shortages or financial challenges. Based on current financial metrics, it is estimated that more than 400 nursing homes could soon close. Simply put, nursing home closures are devastating to residents, their families, staff, and the entire health care system. The chronic underfunding of nursing homes combined with the ongoing toll of the pandemic and a historic labor shortage has been too much to bear for many rural facilities.

While providers greatly appreciate the assistance some LTC centers have received via the Provider Relief Fund throughout this pandemic and the needed extensions of the public health emergency, AHCA remains concerned that unless more is done, additional centers in rural America will close and vulnerable individuals will lose access to quality care. There is limited availability for home- and community-based services (HCBS) in many rural areas equipped to absorb residents looking for alternative LTC options. Additionally, it is unclear whether HCBS is appropriate based on residents' typical high-level of care needs. When nursing homes in rural communities close, the next nearest option for care is often 50 to 100 miles and hours away from the resident's family and friends. This creates LTC deserts and disproportionately impacts our nation's poor and most vulnerable.

There have been multiple media stories about SNF closures across the country. In addition, states from Minnesota to Massachusetts to New York have had to call in the National Guard to simply keep the centers operating due to the workforce crisis.

The viability of SNFs is essential. These LTC centers provide around-the-clock care to those most in need as well as rewarding jobs and careers for local residents. They are an economic hub that allows seniors who have lived in our rural communities for their entire life to remain close to their support structure when LTC is needed. Study after study has shown that these social connections and visitations from their loved ones and long-term friends are very important for their health and well-being.

Any minimum staffing requirements, if pursued, must be realistic and recognize the current workforce and nursing shortage that has been building over a long period of time. Not all healthcare workers want to live in rural areas and that certainly impacts the workforce availability pool. Additional funding to attract a quality workforce would help, along with addressing the backlog in the U.S. immigration system and immigration reform in general (which AHCA/NCAL has heavily advocated for). Federal tuition and loan

forgiveness programs for those in rural and underserved areas serving specifically in SNFs is an example of support that can be provided to help attract more individuals to the LTC profession.

17. **CMS asks:** *What constitutes "an unacceptable level of risk of harm?" What outcomes and care processes should be considered in determining the level of staffing needed?*

AHCA response: CMS already has an existing process in place that allows them to determine an unacceptable level of risk of harm through the survey process that allows them to look at a multitude of outcomes and care processes to include "sufficient nursing staff." AHCA believes the facility also has an existing process (facility assessment) to determine the level of staffing needs as well as a process to identify risks (QAPI). The facility assessment and care plan processes can be utilized to determine the level of staffing needed. A facilities quality assurance and performance improvement processes can also help identify the level of staffing needed as well as address any areas of risk of harm a facility may identify. A number of outcome measures such as quality measures, resident/patient satisfaction, family satisfaction, and staff satisfaction can be utilized to inform

Conclusion

In conclusion, we offer these comments constructively and collegially. AHCA stands ready to work CMS and other SNF stakeholders on COVID-19 recovery as well as other SNF payment and quality efforts. AHCA is eager to schedule time for our members, staff, and researchers to speak with CMS staff to provide an in-depth explanation of our work and to discuss how we collectively could achieve CMS' goals associated with a new SNF payment system and ensure access to quality care, especially for those at risk based on social determinates of health. To schedule such a meeting, please contact Mike Cheek at mcheek@ahca.org.

Sincerely,

President & CEO

CC: Jonathan Blum, Principal Deputy Administrator and Chief Operating Officer
Dr. Meena Seshamani, MD, Ph.D., Deputy Administrator and Director of the Center for Medicare
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