AAPACN
AMERICAN ASSOCIATION OF
POST-ACUTE CARE NURSING

June 8, 2022

Centers for Medicare & Medicaid Services
Washington, DC 20201

Via electronic submission

RE: CMS-1765-P
Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2023

Dear Administrator Brooks-LaSure,

The American Association of Post-Acute Care Nursing (AAPACN) is a professional association representing more than 15,000 long-term and post-acute care (LTPAC) nurses across the country. AAPACN is dedicated to supporting nurses and other health care professionals by providing education, certification, and resources to foster strong, collaborative communities. AAPACN's programs and initiatives support and drive high-quality care in LTPAC settings.

We respectfully submit these comments in response to the Centers for Medicare and Medicaid Services' (CMS's) proposed rule on the Fiscal Year 2023 Skilled Nursing Facility Prospective Payment System (SNF PPS) and updates to the Quality Reporting (QRP) and Value-Based Purchasing (VBP) Programs.

Proposed SNF PPS Rate Setting Methodology and FY2023 Update

We support and appreciate the proposed increase in Medicare rates as a result of the market basket of 2.8% and the 1.5% forecast error application.

Other SNF PPS Issues

Proposed Permanent Cap on Wage Index Decreases
AAPACN supports and thanks CMS for the proposed permanent 5% cap on a decrease to provider's wage index from the prior year. We believe this proposal is beneficial to SNFs and protects them against extreme fluctuations in Medicare rates.

Proposed Changes to SNF PPS Wage Index
CMS proposes to continue to use hospital inpatient wage data to determine FY2023 SNF wage index, as has been done since the inception of the SNF PPS. CMS further states both in the FY 2022 and the FY 2023 proposed rules, "We continue to believe that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable for the SNF PPS." *AAPACN believes that CMS has ample SNF-specific wage data to develop a dedicated SNF wage index. SNFs have utilized*

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the federally mandated Payroll-Based Journaling (PBJ) data since 2016. Further, PBJ data is audited by state surveyors and CMS contractors for accuracy. As such, AAPACN encourages CMS to prioritize development of a SNF-specific wage index to fine tune provider reimbursements for costs such as staff wages.

Technical Updates to PDPM ICD-10 Mappings
AAPACN appreciates CMS's efforts to appropriately align primary ICD-10-CM codes with clinical categories under PDPM. We also agree that there are diagnoses that would be inappropriate to use as a primary diagnosis based on the guidelines in the *ICD-10-CM Official Guidelines for Coding and Reporting*, such as codes with "disease classified elsewhere" or "code first" instructions. *However, AAPACN does not agree with all of the proposals CMS makes to remap codes to "Return to Provider" due to being "unspecified."* The *ICD-10-CM Official Guidelines for Coding and Reporting* manual defines "unspecified codes" on page 9:

> Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an **unspecified code is not provided**, the "other specified" code may represent both other and unspecified

The instructions on page 9 also clarify when the "other" or "other specified" codes may be used:

> Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with "not elsewhere classified" (NEC) in the line designate "other" codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists, so the term is included within an "other" code.

- Proposed Remapping of D75.839
  CMS proposes to remap D75.839 "Thrombocytosis, unspecified," to "Return to provider," stating, "if the cause is unknown, the SNF could use D47.3, 'Essential (hemorrhagic) thrombocythemia' or D75.838, 'Other thrombocytosis.'" AAPACN agrees with the redesignation of D75.839 to "Return to provider," however, we disagree with the guidance to replace this code with either D47.3 or D75.838. This instruction does not align with the *ICD-10-CM Official Guidelines for Coding and Reporting,* which must be followed when assigning codes. The SNF provider would not be able to assign a code of D47.3, "Essential (hemorrhagic) thrombocythemia" without physician documentation to support that the thrombocytosis has no underlying condition as a cause and specifying essential or primary thrombocythemia. In addition, SNF providers can only code D75.838, "Other thrombocytosis" if the physician has identified a more specific cause of the thrombocytosis, but there is not a more specific code available to assign. If the thrombocytosis is truly unspecified, it would not be appropriate to assign the "other" as a diagnosis code, as there is an unspecified code available. *AAPACN recommends CMS issue guidance that aligns with the ICD-10 coding guidance and does not apply blanket statements of replacing one code with a code that may not be supported by physician documentation*.

- Proposed Remapping of D89.44
  CMS also proposes remapping D89.44, "Hereditary alpha tryptasemia" from Medical Management to "Return to provider," noting that this is not a diagnosis that would be treated as primary in the SNF but would be treated in an outpatient setting. In chapter 8, the Medicare Benefit Policy Manual (MBPM) states, "The beneficiary must require SNF care for a condition that was treated during the qualifying hospital stay, or for a condition that arose while in the SNF for treatment of a condition for which the beneficiary was previously treated in the hospital." If a beneficiary was treated for D89.44, "Hereditary alpha tryptasemia," during the hospital stay, it is possible that a skilled level of care in the SNF is required to treat symptoms, which may include pruritis, autonomic disfunction, GI dysmotility, and anaphylaxis. *AAPACN recommends D89.44 continues to map to Medical Management to ensure beneficiaries who are being treated for symptoms of Hereditary alpha tryptasemia are able to access their Medicare benefits.*

  In addition, we would like to note that the MBPM, Chapter 8, section 30.2.2, states (bolded for emphasis):

  > The A/B MAC (A) considers the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a **patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.**

- Proposed Remapping of F32.A
  CMS also proposes remapping F32.A, "Depression, unspecified" from Medical Management to "Return to provider," noting that there are more specific codes that would more adequately capture the diagnosis of depression. However, F32.A also includes "Depression NOS" (not otherwise specified) and "Depressive disorder NOS," which may be appropriate to use if the physician has not documented the depression as "major" or another more specific type of depression. Since F32.A may be the most appropriate diagnosis the coder is able to assign, *AAPACN does not agree with the mapping reassignment to "Return to Provider" for this code.*

- Request for Remapping M62.81
  CMS responds in this proposed rule to the request AAPACN made in the FY 2022 comments regarding the remapping of M62.81 "Muscle weakness (generalized)" from "Return to Provider" to "Other orthopedic." CMS states in the proposed rule that, "we considered the request and determined that muscle weakness (generalized) is nonspecific and if the original condition is resolved, but the resulting muscle weakness persists as a result of the known original diagnosis, there are more specific codes that exist that would account for why the muscle weakness is on-going, such as muscle wasting or atrophy." AAPACN appreciates CMS's response, however, we ask CMS to once again reconsider. AAPACN notes that often the resident has not yet experienced wasting or atrophy (disuse of muscles resulting in decreased muscle mass) but is being treated for muscle weakness to prevent a decline that would result in wasting or atrophy if left untreated. Furthermore, muscle atrophy or wasting (M62.5) are not simply more specific codes of muscle weakness but are entirely different diagnosis codes. We observe that M62.81 is a more specific code listed under M62.8, "Other **specified** disorders of muscle." *AAPACN asks CMS to reconsider the remapping of M62.81, "Muscle weakness (generalized)," to "Other orthopedic" to allow Medicare*

beneficiaries to access Medicare benefits when the beneficiary requires skilled therapy due to the late effects (sequelae) of the resolved condition which resulted in muscle weakness but has not yet resulted in a more severe complication such as muscle wasting or atrophy.

In cases where there is unspecified weakness, the code R53.1, "Weakness" would be assigned. This is a "Return to provider" code, which AAPACN agrees would not be appropriate to use as a primary diagnosis. In contrast, M62.81, "Muscle weakness (generalized)," requires the physician to specify muscle weakness, which may include specific muscle groups or overall muscle weakness, as noted by the nonessential modifier "generalized."

> The *ICD-10-CM Official Guidelines for Coding and Reporting,* clarifies in section I.A.7, (bolded for emphasis) "Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as **nonessential modifiers**."

- Request for Remapping of R62.7
  AAPACN requests that CMS reconsider remapping R62.7 "Adult failure to thrive" from "Return to provider" to Medical Management. CMS notes in the proposed rule, "We considered this request and believe that R62.7 is a nonspecific code and SNF primary diagnoses should be coded to the highest level of specificity. If the patient has been unable to have oral intake, the primary diagnosis (for example, Ulcerative Colitis) for admission to a SNF should explain why the patient is unable to have oral intake sufficient for survival." AAPACN requests that CMS consider that for many complex frail elderly residents, the direct cause of failure to thrive may be multifaceted and not a result of one primary underlying condition. The *American Family Physician* journal article, "Geriatric Failure to Thrive" (https://www.aafp.org/afp/2004/0715/p343.html) describes failure to thrive in elderly patients as a "state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments." The article further notes, "The elderly patient with declining health poses significant challenges for attending physicians. Often, the **cause or causes of the deterioration are not identifiable** or are irreversible." The article also sites that failure to thrive affects 25 to 40 percent of nursing home residents. In cases where the physician is unable to identify the cause or causes of the decline and the patient is receiving a skilled level of care, it would be appropriate for SNF staff to assign R62.7, "Adult failure to thrive" as the primary reason for skilled care.

- Request for Remapping "unacceptable principal diagnosis" codes from Medicare Code Edit manual
  Again, AAPACN appreciates CMS's efforts to appropriately align primary ICD-10-CM codes with clinical categories under PDPM. However, AAPACN is concerned with a recent update to the Definitions of Medicare Code Edits ICD-10 Version, v39.1, released April 2022, which lists "unacceptable principal diagnosis," starting on page 227, identifying diagnoses that currently map to a clinical category. This results in a disconnect for SNF staff selecting a primary diagnosis for MDS item I0020B. A primary diagnosis selection that maps to a clinical category on the PDPM mapping file in these cases will be denied for use as a principal diagnosis on the Medicare claim at the Medicare Administrative Contractor. On the PDPM Frequently Asked Questions document, at question 1.8, which addresses if the principal diagnosis on the SNF claim is required to match the

primary diagnosis coded in item I0020B, CMS stated, “While we expect that these diagnoses should match, there is no claims edit that will enforce such a requirement.” Since CMS expects the principal diagnosis and I0020B diagnosis to match, we encourage CMS to reconcile the “unacceptable principal diagnosis list” with the PDPM ICD-10-CM mapping file to ensure that diagnosis codes that will not pass claim edits are not mappable to a clinical category.

AAPACN encourages CMS to consider the following changes to ICD-10-CM codes from the unacceptable principal diagnosis list:

ICD-10-CM Code	Description	Current Mapping	Suggested Mapping
R402340	Coma scale, best motor, flexion withdrawal, unsp time	Medical Management	Suggest mapping change to “Return to Provider” Rationale: The coma itself would not substantiate skilled need.
R402341	Coma scale, best motor, flexion withdrawal, in the field	Medical Management	
R402342	Coma scale, best motor response, flexion withdrawal, EMR	Medical Management	
R402343	Coma scale, best motor response, flexion withdrawal, admit	Medical Management	
R402344	Coma scale, best motor response, flexion withdrawal, 24+hrs	Medical Management	

S06A0XA	Traumatic brain compression without herniation, init	Acute Neurologic	Suggest mapping change to “Return to Provider” Rationale: These are NOS codes with a “code first” instruction.
S06A0XD	Traumatic brain compression without herniation, subs	Acute Neurologic	
S06A0XS	Traumatic brain compression without herniation, sequela	Acute Neurologic	
S06A1X	A Traumatic brain compression with herniation, init	Acute Neurologic	
S06A1XD	Traumatic brain compression with herniation, subs	Acute Neurologic	
S06A1XS	Traumatic brain compression with herniation, sequela	Acute Neurologic	

Z439	Encounter for attention to unspecified artificial opening	Medical Management	Suggest mapping change to “Return to Provider” Rationale: Unspecified artificial opening does not provide enough

			information to support skilled care.
Z902	Acquired absence of lung [part of]	Medical Management	Suggest mapping change to "Return to Provider" Rationale: The lack of the lung would not be the skilled need, but the resultant condition could be.

Z98890	Other specified postprocedural states	Medical Management	Suggest mapping change to "Return to Provider" Rationale: State/status codes would not indicate a skilled need.

R402210	Coma scale, best verbal response, none, unspecified time	Medical Management	Suggest mapping change to "Return to Provider" Rationale: The coma itself would not substantiate a skilled need.
R402211	Coma scale, best verbal response, none, in the field [EMT or ambulance]	Medical Management	
R402212	Coma scale, best verbal response, none, at arrival to emergency department	Medical Management	
R402213	Coma scale, best verbal response, none, at hospital admission	Medical Management	
R402214	Coma scale, best verbal response, none, 24 hours or more after hospital admission	Medical Management	
R402220	Coma scale, best verbal response, incomprehensible words, unspecified time	Medical Management	
R402221	Coma scale, best verbal response, incomprehensible words, in the field [EMT or ambulance]	Medical Management	
R402222	Coma scale, best verbal response, incomprehensible words, at arrival to emergency department	Medical Management	

R402223	Coma scale, best verbal response, incomprehensible words, at hospital admission	Medical Management	
R402224	Coma scale, best verbal response, incomprehensible words, 24 hours or more after hospital admission	Medical Management	
R402310	Coma scale, best motor response, none, unspecified time	Medical Management	
R402311	Coma scale, best motor response, none, in the field [EMT or ambulance]	Medical Management	
R402312	Coma scale, best motor response, none, at arrival to emergency department	Medical Management	
R402313	Coma scale, best motor response, none, at hospital admission	Medical Management	
R402314	Coma scale, best motor response, none, 24 hours or more after hospital admission	Medical Management	
R402320	Coma scale, best motor response, extension, unspecified time	Medical Management	
R402321	Coma scale, best motor response, extension, in the field [EMT or ambulance]	Medical Management	
R402322	Coma scale, best motor response, extension, at arrival to emergency department	Medical Management	
R402323	Coma scale, best motor response, extension, at hospital admission	Medical Management	
R402324	Coma scale, best motor response, extension, 24 hours or more after hospital admission	Medical Management	
R402110	Coma scale, eyes open, never, unspecified time	Medical Management	
R402111	Coma scale, eyes open, never, in the field [EMT or ambulance]	Medical Management	
R402112	Coma scale, eyes open, never, at arrival to emergency department	Medical Management	
R402113	Coma scale, eyes open, never, at hospital admission	Medical Management	
R402114	Coma scale, eyes open, never, 24 hours or more after hospital admission	Medical Management	
R402120	Coma scale, eyes open, to pain, unspecified time	Medical Management	

R402121	Coma scale, eyes open, to pain, in the field [EMT or ambulance]	Medical Management	
R402122	Coma scale, eyes open, to pain, at arrival to emergency department	Medical Management	
R402123	Coma scale, eyes open, to pain, at hospital admission	Medical Management	
R402124	Coma scale, eyes open, to pain, 24 hours or more after hospital admission	Medical Management	

G9200	Immune effector cell-associated neurotoxicity syndrome, grade unspecified	Acute Neurologic	Suggest mapping change to "Return to Provider" Rationale: These codes utilize a "code first" instruction.
G9201	Immune effector cell-associated neurotoxicity syndrome, grade 1	Acute Neurologic	
G9202	Immune effector cell-associated neurotoxicity syndrome, grade 2	Acute Neurologic	
G9203	Immune effector cell-associated neurotoxicity syndrome, grade 3	Acute Neurologic	
G9204	Immune effector cell-associated neurotoxicity syndrome, grade 4	Acute Neurologic	
G9205	Immune effector cell-associated neurotoxicity syndrome, grade 5	Acute Neurologic	

B960	Mycoplasma pneumoniae [M. pneumoniae] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	Suggest mapping change to "Return to Provider" Rationale: The coding guidance indicates a disease classified elsewhere manifestation – etiology should be coded first.
B961	Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9620	Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9621	Shiga toxin-producing Escherichia coli [E. coli] [STEC] O157 as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9622	Other specified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9623	Unspecified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	

B9629	Other Escherichia coli [E. coli] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B963	Hemophilus influenzae [H. influenzae] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B964	Proteus (mirabilis) (morganii) as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B965	Pseudomonas (aeruginosa) (mallei) (pseudomallei) as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B966	Bacteroides fragilis [B. fragilis] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B967	Clostridium perfringens [C. perfringens] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9681	Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9682	Vibrio vulnificus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9689	Other specified bacterial agents as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B970	Adenovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9710	Unspecified enterovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9711	Coxsackievirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9712	Echovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9719	Other enterovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9721	SARS-associated coronavirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9729	Other coronavirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9730	Unspecified retrovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9731	Lentivirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9732	Oncovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	

B9733	Human T-cell lymphotrophic virus, type I [HTLV-I] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9734	Human T-cell lymphotrophic virus, type II [HTLV-II] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9735	Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9739	Other retrovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B974	Respiratory syncytial virus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B975	Reovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B976	Parvovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B977	Papillomavirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9781	Human metapneumovirus as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	
B9789	Other viral agents as the cause of diseases classified elsewhere	Acute Infection [Medical Management]	

In addition, AAPACN has identified several humeral fracture codes which are not eligible for "one of the two orthopedic surgery categories" for select encounter codes but are available for other encounter codes. One example is S42.201B, "Unspecified fracture of upper end of right humerus, initial encounter for open fracture," which maps to the Non-Surgical Orthopedic/Musculoskeletal clinical category and is also eligible for mapping to "one of the two orthopedic surgery categories" based on the coding of a related surgical procedure. However, the following S42.201 codes with encounter codes A, D, G, K, and P are not eligible for one of the two orthopedic surgery categories:

ICD-10-CM Code	Description	Default Clinical Category	Resident Had a Major Procedure during the Prior Inpatient Stay that Impacts the SNF Care Plan?
S42201A	Unspecified fracture of upper end of right humerus, initial encounter for closed fracture	Non-Surgical Orthopedic/Musculoskeletal	**Suggest allowing eligibility for mapping to one of the two**

S42201D	Unspecified fracture of upper end of right humerus, subsequent encounter for fracture with routine healing	Non-Surgical Orthopedic/Musculoskeletal	**orthopedic surgery categories**
S42201G	Unspecified fracture of upper end of right humerus, subsequent encounter for fracture with delayed healing	Non-Surgical Orthopedic/Musculoskeletal	
S42201K	Unspecified fracture of upper end of right humerus, subsequent encounter for fracture with nonunion	Non-Surgical Orthopedic/Musculoskeletal	
S42201P	Unspecified fracture of upper end of right humerus, subsequent encounter for fracture with malunion	Non-Surgical Orthopedic/Musculoskeletal	

In addition to the above example, AAPACN requests that CMS consider this same remapping for eligibility into one of the two orthopedic surgery categories for all encounter codes of the following diagnoses: S42.202, S42.211, S42.212, S42.214, S42.415, S42.221, S42.222, S42.224, S42.225, S42.231, S42.232, S42.241, and S42.242.

<u>Request for Information: Infection Isolation</u>

AAPACN appreciates CMS opening the discussion on infection isolation. AAPACN understands that at the time the guidance and instructions for O0100M, Isolation or quarantine for active infectious disease, were established, they were not written with a global pandemic in mind. There is a significant cost and resource requirement for residents in infection isolation, whether cohorted in a shared room, in an isolation unit, or in a private room. When COVID units or wings were established, this often resulted in dedicated staff and resources only to these residents, resulting in a higher than usual PPD. Additionally, the PPE use was very comparable, regardless of location, due to the changing of certain PPE between instances of resident care. Additional resources were also used to bring all services to the resident into their room, regardless of cohorting or not.

AAPACN respectfully requests that CMS adopt one of the following suggestions:

- remove “single room” from the isolation criteria and add “cohorting” with the same or similar infection; or
- code either “single room isolation” or “cohorted isolation.” In this option, cohorted isolation would result in a lower CMI achievement, such as Special Care High in the nursing component, and may or may not qualify for the point in the NTA component. This would provide some compensation for the resources used for cohorted isolation, rather than no compensation.

Recalibrating the PDPM Parity Adjustment

AAPACN appreciates CMS's transparency regarding its approach to recalibrating the PDPM parity adjustment to ensure budget neutrality with the implementation of PDPM. Overall, AAPACN continues to have concerns with the overarching effect the COVID-19 PHE had on beneficiaries, the data used for analysis, and the negative effects of a full implementation without phase-in.

AAPACN continues to believe that COVID-19 affected all beneficiaries during the PHE, regardless of whether or not they contracted COVID-19. A Clinical Psychology Review article in April 2021 noted that "countless people will suffer a negative mental health outcome due to COVID-19, with already vulnerable and underserved populations at disproportionate risk." Additionally, acknowledging the increased risks of negative mental health impact, the CDC is now recognizing a significant list of post-COVID or "long-haul" effects which affect patients long-term following a COVID-19 infection. Medicare beneficiaries admitted to SNFs following a COVID-19 infection may have suffered from post-COVID symptoms, but since the post-COVID diagnosis (U09.9) was not available until Oct. 1, 2021, this condition would not be reflected on the MDS or claim. The CDC lists general post-COVID symptoms, such as fatigue which interferes with daily life, malaise, and fever. Post-COVID symptoms can also be more severe, including respiratory and heart symptoms, neurological, digestive, or symptoms involving pain in the joints or muscles, and rashes. Many of these post-COVID clinical symptoms may have impacted beneficiaries during the analysis period by extending their Medicare stay longer than would have occurred without the symptoms and would increase the amount of resources needed for their care.

Regarding the data timeframe used for analysis, AAPACN supports the analysis of data from October 2019 through March 2020, as well as April through July 2021. Conversely, AAPACN believes August and September 2021 should be excluded due to the COVID-19 Delta variant surge.

CMS proposed to fully implement the PDPM parity adjustment for FY 2023. AAPACN opposes a one-time phase in and encourages CMS to phase in the adjustment over three fiscal years. AAPACN believes this will account for any overpayment CMS identifies during the final analysis and mitigate the negative impact of implementing the full adjustment during one fiscal year. A majority of SNFs continue to face a dire financial situation with the ongoing COVID-19 PHE, the high cost of labor and goods, and staff shortages resulting in even higher-cost agency staff. Many SNFs operate with a narrow profit margin. In 2019, the national median for net margin was 0.21% (Skilled Nursing News, January 8, 2020). While underfunded Medicaid payments are directly correlated to financial viability challenges, the current inflation of the cost of labor and goods has compounded this problem. If CMS finalizes the 4.6% cut to Medicare reimbursement and implements the full reduction during one fiscal year, this may force facilities into a negative profit margin—which would likely result in the closure of facilities, having a direct negative impact on the Medicare beneficiaries they serve. *AAPACN believes that the phased-in approach over three fiscal years would result in the least amount of disturbance to the services provided to Medicare beneficiaries.*

In addition, AAPACN encourages CMS to use an equally applied approach to CMI adjustments for the final parity adjustment percentage across all components. AAPACN believes the targeted approach, which results in a larger reduction for some case-mix indices, may have unintended adverse effects on some facilities. For example, in the nursing component, the percentage of change in the CMI is greater, by approximately 0.3%, for Extensive Services groups than it is for most of the Special Care Low groups. This may result in a greater impact in payment reduction for facilities with high numbers of beneficiaries with tracheostomies, ventilators, or receiving infection isolation. AAPACN believes an equally distributed percentage reduction would have a more equitable impact on all facilities.

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

Influenza Vaccination Coverage among Healthcare Personnel (HCP)
AAPACN supports CMS's increased focus on infection control and safety of Medicare beneficiaries but wishes to outline serval concerns. First, AAPACN is concerned that the vaccination measure does not align with the Improving Medicare Post-Acute Care Transformation (IMPACT) Act (Public Law 113-185), which requires the reporting of standardized patient assessment data. This measure focuses on data collected on healthcare personnel, rather than patient data. While AAPACN understands the rationale CMS provided regarding how this measure applies to beneficiary safety, we do not believe it would provide useful data to consumers. Second, public reporting of this measure would provide the previous influenza season's data to consumers and would not reflect the vaccination rates for the current influenza year. Influenza vaccine effectiveness varies greatly year to year, and even high vaccination rates may not protect the beneficiary from contracting influenza. AAPACN believes public reporting of this data may be misleading to consumers due to changes in staffing from one influenza season to the next, the effectiveness of the vaccine, and that the measure includes all HCP regardless of possible contact with the Medicare beneficiary. Finally, AAPACN is concerned that this measure uses facility resources entering data into NHSN, which diverts resources that could be directed toward the beneficiaries. *AAPACN encourages CMS to delay implementation of this measure during the ongoing COVID-19 PHE and simultaneous national nursing staffing crisis.*

Proposal to Start Data Collection for Two Transfer of Health (TOH) Information Measures and SPADES Starting on the MDS 3.0 v1.18.11
AAPACN believes that Medicare beneficiaries would benefit from the initiation of the two Transfer of Health (TOH) Information measures. Since this measure collects data on a process that is already being completed in the facilities, it does not require a substantial amount of additional staff resources.

However, AAPACN is concerned with the expediated timeline and training needs of the proposed implementation of the MDS 3.0 v1.18.11 item set, which includes up to 59.5 changes to the MDS. We believe this may be overwhelming to facilities during the ongoing PHE and national staffing crisis. In addition, CMS noted that v1.18.11 is similar to the 1.18.1 item set, which included the removal of section G. AAPACN believes other impending MDS change such as the addition of the SPADES, and the removal of section G, will require a substantial amount of training. The training need is not limited to replacing section G with GG functional abilities, but retraining on all items impacted by section G. The activities of daily living, from section G, have a substantial influence on Medicaid reimbursement, Quality Measures, Care Area Triggers, appendix C Care Area Assessment (CAA) resources, and care plans. This amount of change would be manageable during normal times but may be detrimental to facilities during the PHE and national staffing crisis. *AAPACN encourages CMS to wait until two full fiscal years after the end of the PHE to implement all of the SPADEs and the removal of section G*.

SNF QRP Quality Measures Under Consideration for Future Years - RFI
With regard to adding the PAC-COVID-19 Vaccination Coverage among Patients measure, AAPACN believes this data could be misleading to consumers if it is collected in a similar way to the influenza vaccinations among patients from MDS data. The QRP measures only collect data on PPS MDS assessments, and therefore only represent Medicare Part A beneficiaries, a small portion of a SNFs census; applying the same method to COVID-19 vaccination coverage would not accurately reflect the facility resident population. In contrast, if CMS decides to collect COVID-19 vaccination data among residents for all residents and not just Medicare beneficiaries, that would connect Medicare funding to processes that do not involve Medicare beneficiaries. *AAPACN believes further information on how this measure would be collected and reported is necessary before we can provide additional feedback on the proposal's potential impact*.

Overarching Principles for Measuring Equity and Healthcare Quality Disparities across CMS Quality Program – RFI
To effectively address equity and healthcare quality disparities, AAPACN encourages CMS to focus any future measures on aspects that facilities can control. For example, some identified healthcare disparities could be used in mitigation strategies to help improve outcomes. However, quality measures should be focused on measurable outcomes. In this context, measures should focus on data the facility can use to identify any actual or potential health disparities and apply to improve outcomes and effectively care plan for residents. *AAPACN agrees that identifying health disparities can be an effective tool in risk adjusting measures as covariates.*

AAPACN looks forward to any opportunity to learn more about the specific measures and approaches CMS plans to make in the future.

Inclusion of the CoreQ: Short Stay Discharge Measure in a Future SNF QRP Program Year – Request for Information (RFI)
Overall, AAPACN supports the implementation of the CoreQ to report the resident experience in the SNF. However, AAPACN seeks to better understand how this measure would impact the SNF QRP program since the QRP program measures facilities on their ability to report data, and the CoreQ is administered by a third party. For example, would there be possible penalties if residents do not complete the survey?

Additionally, AAPACN suggests that this measure is more appropriate to use in a value-based purchasing program. For the SNF QRP program (or VBP), AAPACN does not support using data from all payers to affect only Medicare reimbursement. For example, a resident on a Medicare Advantage (MA) plan may have a negative experience (such as denial of service or an end of skilled care) which resulted solely from a decision of the MA plan; nevertheless, residents' survey responses may reflect that experience toward the facility. *Since this impact is not within the control of the SNF, AAPACN does not believe it would be appropriate to use these payer types in any future measure. AAPACN does support the minimum case number of Medicare stays to calculate and publicly report findings.*

Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

While we thank CMS for its efforts to adjust and provide reliable data to consumers, AAPACN does not support the methods proposed. AAPACN understands that the statute requires CMS to withhold 2% of Medicare funds for the SNF VBP program, yet we observe that CMS has the authority to disburse withheld funds. *AAPACN suggests that CMS consider awarding 70% back to the SNFs to help reduce the burden of the suppressed measure.* With the proposed suppression, participating facilities would be faced with a 0.8% reduction in Medicare payment due to CMS awarding only 1.2% back to facilities. Increasing the award to the full 70% would help award more Medicare payments back to the SNFs with the suppressed measure.

Request for Feedback on Four Options to Adjust for COVID-19 in Relationship to SNF VBP SNF 30-Day All-Cause Readmission Measure (SNFRM)
AAPACN supports CMS's efforts to adjust for beneficiaries with COVID-19, which may have had an adverse effect on facility SNF VBP outcomes. *AAPACN specifically supports CMS's Option 4, which would exclude patients with a COVID-19 diagnosis. AAPACN observes that this option best allows for the measures to be calculated but removes beneficiaries who were directly affected by a COVID-19 infection.*

Proposal to Adopt SNF Healthcare Associated Infections (HAI) for SNF VBP FY 2026 Program Year
Overall, AAPACN supports the adoption of this measure in the SNF VBP program. However, for SNFs to effectively improve in this measure, *AAPACN encourages CMS to develop reporting in CASPER.* SNFs must be able to monitor performance over time and meaningfully work toward process improvement. The delay in reports hinders facilities' ability to achieve timely improvement in this measure.

Proposal to Adopt Total Staffing Measure for SNF VBP FY 2026 Program Year
AAPACN does not support this measure at this time. AAPACN believe this is not an appropriate time for a staffing measure given the current national staffing crisis. Many facilities are using temporary agency staffing while also offering inflated wages to attract staff yet report that despite their efforts there are not enough qualified individuals available to fill all of the open positions. *AAPACN encourages CMS to work actively on rebuilding the nursing workforce before measuring and penalizing facilities due to a national shortage of nurses.*

AAPACN further opposes the methodology used to case-mix adjust the staffing data using STRIVE (Staff Time and Resource Intensity Verification) data, which was introduced in 1998 and then updated using data collected in 2006 and 2007. On its website Time Study (STRIVE), CMS noted changes in data from 1998 to 2007, *"RUG-III related resource times and payment rates has suggested that SNF care patterns have changed over the decade since the last STM studies."* In the 15 years since the STRIVE data was last collected, substantial changes in resources and SNF care patterns have occurred; these are not reflected or accurate captured in the STRIVE time study. In addition, the RUG-IV model, which was used in the updated STRIVE study, was replaced in 2019 with the Patient-Driven Payment Model (PDPM*). AAPACN strongly encourages CMS to complete an updated staff time study to reflect the changes in resources and care patterns before proposing a measure that would potentially reduce Medicare payment to the SNF.*

AAPACN also encourages CMS to identify the value of the resident experience in SNFs in an approach similar to how the patient experience is valued in home health and hospitals. The National Quality Forum has endorsed all five CoreQ measures, and it is independently tested as valid and reliable. Since the CoreQ requires administration by a third party, AAPACN encourages CMS to consider funding the administration of the CoreQ using a portion of the SNF VBP withholdings (currently 40%) that is not paid back to the SNFs through incentive payments. *AAPACN believes that a patient satisfaction survey better aligns with the current goals of the SNF QRP and VBP programs. In contrast, AAPACN believes staffing data potentially penalizes facilities when the workforce to improve staffing is just not available.*

Proposal to Adopt Discharge to Community Post-Acute Care (DTC-PAC) for SNF VBP FY 2027 Program Year

AAPACN supports the adoption of DTC-PAC into the SNF VBP but is concerned about the length of time between the baseline years, performance years, and program year. This creates a challenge for facility staff to make meaningful changes toward improvements. Without real-time, actionable data, it may be nearly impossible for facilities to identify the root cause of why a discharge to community was unsuccessful, especially if the resident did not return to the same SNF after the hospitalization.

In addition, AAPACN is concerned that the baseline year includes FY 2021 - FY 2022 data. Many beneficiaries who needed skilled care during this time may have prematurely discharged back to the community due to the fear and stigma of being in a skilled nursing facility, regardless of the presence or absence of an active COVID-19 infection in the facility. A majority of facilities have experienced a decline in census, with occupancy half of what it was prior to the PHE. This lower occupancy may also have an adverse effect on facilities' outcomes. AAPACN notes that CMS has suppressed the SNFRM data for FY 2022 and proposed to suppress data for FY 2023 due to the impact the COVID-19 PHE had on the data during FY 2020 and FY 2021*. As such, AAPACN encourages CMS to consider likewise delaying the implementation of this measure until the program year will not include baseline data which was previously suppressed for existing measures.*

AAPACN also seeks clarification on whether CMS will apply the same methodology to account for COVID-19 for SNF VBP (we supported option 4 above) for SNFRM to any of the proposed measures which utilize data during the COVID-19 PHE.

Proposal to Add Additional Validation Methods for SNFRM and Other VBP Measures

The current SNFRM uses solely Medicare claims data, as do the proposed SNF HAI and DTC-PAC data. Any additional data validation on these measures would not have a substantial impact on provider resources. However, any results of such validation efforts may provide valuable data to the SNF to ensure the accuracy of these measures. In contrast, the newly proposed Total Staffing Measure would require validation of both Payroll-Based Journaling (PBJ) data and MDS data. As stated earlier, AAPACN does not support the implementation of this measure. However, if implemented, the additional medical reviews necessary to validate the MDS and/or PBJ data may result in shifting resources to these reviews rather than on beneficiaries. AAPACN further notes that PBJ data and MDS data is currently reviewed for accuracy during the health inspection process, but that process does not entail the validation contemplated in the proposed Total Staffing Measure. *AAPACN suggests that CMS introduce additional validation methods if it proceeds with adoption of this Measure.*

Thank you for the opportunity to provide these comments. We are glad to serve as a resource for HHS and CMS. Please contact Amy Stewart, Vice President of Education and Certification Strategy, astewart@aapacn.org, if you have any questions about these comments or AAPACN's work to support skilled nursing professionals.

Sincerely,

Tracey Moorhead
President and CEO