June 8, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-1765-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "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" in the *Federal Register*, vol. 87 no. 73, p. 22720 (April 15, 2022). We appreciate CMS's ongoing efforts to administer and improve the payment system for skilled nursing facilities, particularly given the many competing demands on the agency's staff.

The Commission's comments are organized into five sections: (1) the proposed update to SNF payment rates for fiscal year (FY) 2023, including the forecast error adjustment; (2) the recalibration of the patient-driven payment model (PDPM) parity adjustment; (3) the proposed cap on wage index decreases; (4) the quality reporting program, including selection of new measures and overarching principles for measuring equity and healthcare quality disparities across CMS quality programs; and (5) the value-based purchasing program.

<u>Proposed FY 2023 update to the Medicare payment rates for SNFs</u>

CMS proposes to increase the SNF payment rates by 3.9 percent. This reflects a 2.8 percent SNF market basket update minus a 0.4 percentage point multifactor productivity adjustment (both required by law), plus a 1.5 percentage point forecast error adjustment. Since 2003, CMS has adjusted the market basket percentage update to reflect forecast error if the difference between the forecasted and actual change in the market basket exceeds a specified threshold (0.5 percentage point). For FY 2021 (the most recently available final data), the forecasted increase in the SNF market basket was 2.2 percentage points and the actual increase was 3.7 percentage points, for a difference of 1.5 percentage points. Because the difference exceeds the threshold, CMS proposes to increase the market basket update by 1.5 percentage points.

Comment

The Commission understands that by law CMS is required to update the SNF prospective payment system (PPS) rates by the market basket minus a productivity adjustment. That said, after reviewing many factors—including indicators of beneficiary access, the volume of services, the supply of providers, and access to capital—the Commission recommended in its March 2022 report that the Congress reduce the 2022 Medicare base payment rates by 5 percent for FY 2023. The aggregate Medicare margin for freestanding SNFs in 2020 was 16.5 percent, the 21st consecutive year that this margin has exceeded 10 percent. If we allocate a portion of the reported federal relief funds to Medicare payments, we estimate that the aggregate Medicare margin was 19.2 percent. While the effects of the pandemic on beneficiaries and nursing home staff have been devastating, the combination of federal relief policies and the implementation of the new case-mix system resulted in overall improved financial performance for SNFs. The high level of Medicare's payments indicates that a reduction is needed to more closely align aggregate payments to aggregate costs.

Although CMS is required by statute to update the payment rates each year by the estimated change in the market basket index, it is not required to make automatic forecast error corrections. Consistent with the Commission's comments on the proposed rules for FY 2008 and FY 2022, we do not support the triggering of automatic forecast error adjustments. An automatic forecast correction would, in some years (like this one), result in making a payment increase on top of the statutory increases to the payment rates, even though the industry has sizable average Medicare margins. Furthermore, eliminating the automatic adjustments would also result in more stable updates and consistency across settings. We note that, except for the updates to the capital payments to acute care hospitals, CMS does not apply automatic forecast error adjustments to any other market basket updates.

Recalibration of the PDPM parity adjustment to ensure budget neutrality

When a new case-mix classification system is implemented, CMS must estimate its impacts on payments and make a "parity adjustment" to the new payment rates so that the case-mix changes are budget neutral and do not, by themselves, increase or decrease aggregate payments to providers. In FY 2020, CMS implemented a new case-mix system for SNFs, the patient driven payment model (PDPM). Anticipating behavioral responses to the new case-mix system (most notably decreases in the amount of therapy furnished to patients), CMS preemptively adjusted the case-mix indexes for all case-mix groups to ensure budget neutrality.

CMS has continued to monitor SNF utilization data under the PDPM to ensure that the original parity adjustment it made in FY 2020 was sufficient. Last year, in its analysis of FY 2020 data, CMS observed significant differences between expected and actual SNF payments and service use that warranted an additional parity adjustment to bring payments under the new case-mix system in line with payments under the prior system.[1] In estimating the difference in expected

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[1] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2021. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; updates to the Quality Reporting

and actual payments, CMS attempted to isolate the effects of the PDPM from the PHE by excluding waiver-related admissions and admissions of beneficiaries with COVID-19 diagnoses.[2] In the final rule, CMS did not lower payments (by the estimated 5 percent) and stated it would consider stakeholders' comments on the methodology used to estimate the parity adjustment, in the FY 2023 proposed rule.

In this year's proposed rule, CMS responds to stakeholders' comments on the methodology to isolate the effects of the PDPM from the PHE by: expanding the number of codes used to exclude COVID-19 cases from the calculation of the parity adjustment; adding an examination of the codes recorded in the MDS patient assessment data; excluding stays that spanned the prior and the new case-mix systems; and examining data from a "control period" with limited impacts from the PHE—October 1, 2019, through March 2020 and April 1, 2021, through September 2021 (a period of relatively low COVID-19 prevalence in nursing homes). Using the subset population (net of the exclusions) and the control period, CMS estimates that the difference between actual SNF payments and expected payments warrants a parity adjustment of –4.6 percent. CMS proposes to apply this adjustment equally to all case-mix indexes for all case-mix groups.

CMS proposes to implement the parity adjustment with no transition, stating that the industry has already had a one-year delay in the application of the adjustment. The parity adjustment would lower payments by $1.7 billion. This reduction would be largely offset by the 3.9 percent proposed increase in the market basket update, for a combined net reduction to payments of 0.7 percent, or $320 million.

Comment

The Commission recognizes the difficulties inherent in teasing out the impacts of the PDPM from the PHE, and we acknowledge that there is likely no perfect solution. That said, we consider CMS's proposed approach to estimating the parity adjustment to be reasonable. The revised methodology proposed for FY 2023 addresses many of the key issues raised by stakeholders. We also support CMS's proposal to apply the parity adjustment evenly over all case-mix indexes for all case-mix groups, the same approach that was taken when the original adjustment was implemented.

In our comments on the FY 2022 SNF PPS proposed rule, the Commission supported a delayed implementation of a recalibrated parity adjustment, given the continued impact of the PHE on SNF providers. We also stated that when the parity adjustment was eventually implemented, a phase-in might not be warranted, given the high level of aggregate payments to SNFs. In our March 2022 report to the Congress, we reported that the aggregate SNF Medicare margin in 2020 was the highest it has been since 2011. Therefore, for FY 2023, the Commission supports a

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Program and Value-Based Purchasing Program for federal fiscal year 2022. Proposed rule. *Federal Register* 86, no. 71 (April 15): 19954–20022.

[2] During the public health emergency (PHE), CMS waived certain coverage requirements, such as a prior three-day hospital stay.

full implementation of the proposed parity adjustment, without a phase-in. The industry has been on notice for a year that an additional reduction to the payment rates would be necessary to maintain budget neutrality. We note that the parity adjustment proposed for FY 2023 is smaller than the industry might have expected, given CMS's earlier estimate. We also note that CMS estimates that it has overpaid the industry about $1.7 billion per year since the PDPM was implemented in FY 2020, or about $5.1 billion.

Proposed cap on wage index decreases

For FY 2023 and subsequent years, CMS proposes applying a 5 percent cap on any decrease to a SNF's wage index from its wage index in the prior year, regardless of the reason for the decrease. CMS contends that applying a 5 percent cap will help mitigate instability and significant negative impacts to providers' payments resulting from changes to the wage index. New SNFs would be paid the wage index for the area in which they are geographically located for their first full or partial fiscal year, with no cap applied.

Comment

The Commission supports the proposed 5 percent cap on wage index decreases. However, we contend that the cap should apply not just to wage index decreases but to increases as well, so that no provider would have its wage index value increase or decrease by more than 5 percent in any given year. Consistent with CMS's proposed approach, the implementation of the revised wage index values (where changes are limited to plus or minus 5 percent) should be done in a budget-neutral manner.

The SNF quality reporting program (QRP): Selection of new measures

CMS seeks comment on the inclusion of the CoreQ: Short Stay Discharge Measure in the SNF QRP and future measure concepts for the SNF QRP.

Comment

The Commission maintains that Medicare quality programs should include population-based measures tied to clinical outcomes, patient experience, and value/resource use. Across the health care system, research finds that improving patient experience translates to better health. Patients who feel heard and have positive care experiences report better health outcomes and are more likely to adhere to treatment plans. The Commission recently recommended that the Secretary should finalize development of and begin to report patient experience measures for SNFs.[3] We support CMS considering the inclusion of the CoreQ survey as a measure of patient experience in the SNF VBP program.

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[3] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

The CoreQ survey for short-stay residents includes four items that ask beneficiaries if they would recommend their facility, how they rate the staff and the care they received, and whether their discharge planning needs were met. The CoreQ survey is already in use in many SNFs, so it could be implemented into the SNF QRP more quickly than other surveys of patient experience. However, given the limited number of questions, the CoreQ survey may not fully reflect patient experience at a given facility.

Alternatively, the Agency for Healthcare Research and Quality (AHRQ) has developed three nursing home Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey instruments for long-stay residents, short-stay patients who are discharged, and family members.[4] These surveys include roughly 50 questions about various aspects of care and experience during a stay, including safety, cleanliness, timeliness of nursing staff, and overall rating of the facility. Some observers contend that the CAHPS surveys have too many questions. We encourage AHRQ and CMS to continue development of a refined CAHPS survey that is shorter than its current versions but would capture more aspects of patient experience than the CoreQ survey. CMS should also finalize the development of the CAHPS surveys into quality measures that are adjusted for respondent characteristics (e.g., sex, age, education, whether a proxy completed the survey). CMS would also need to implement a process for third-party survey vendors to collect survey results from patients (or their proxies).

As CMS considers other measures for inclusion in the SNF QRP, at this time, we continue to caution against the inclusion of measures based on provider-reported MDS assessment data, such as measures of change in or attainment of mobility. As we reported in our June 2019 report to the Congress, the inconsistency of facilities' recording of functional assessment information, such as change in mobility, raises questions about using such information for quality reporting or payment.[5] Still, maintaining and improving these outcomes are critically important to patients, so we encourage CMS to seek ways to improve the reporting of assessment data so that these outcomes might be adequately assessed. In the Consolidated Appropriations Act, 2021 (CAA), the Congress required and provided funding to CMS to implement a validation of quality data used in the expanded SNF VBP program that may be similar to the validation of inpatient quality data (i.e., chart review of some measure results for a sample of hospitals). After this validation process is put in place, and if the accuracy of the provider-reported assessment data improves, then CMS should consider including them in the SNF QRP program.

The SNF QRP: Overarching principles for measuring equity and health care quality disparities across CMS quality programs

CMS is working to advance health equity by designing and implementing policies and programs that support health for all beneficiaries. Accounting for health care disparities in quality measures is a cornerstone of the agency's approach to advancing health care equity. CMS has

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[4] CAHPS is a registered trademark of AHRQ, a U.S. government agency.

[5] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

proposed quality measure stratification (measuring performance differences among subgroups of beneficiaries) as a tool to address health care disparities and advance health equity. In this proposed rule, CMS requests information on principles and approaches that could be used in the SNF Quality Reporting Program (QRP) and other quality programs to stratify measure results.

Approaches for measures stratification

CMS identifies two approaches for reporting stratified measures: 1) "within-provider disparity method," which would compare measure performance results for a single measure between subgroups of patients with and without a given factor (e.g., dual-eligible beneficiaries and others), and 2) "between-provider disparity methodology," which would report performance on measures for only the subgroup of patients with a particular social risk factor, allowing providers to compare their performance for the subgroup to state and national benchmarks.

Prioritizing measures for disparity reporting

CMS proposes a set of principles to prioritize measures for disparity reporting in quality reporting programs. These principles include prioritizing measures that: 1) meet industry standards for measure reliability and validity, 2) have evidence that the outcome being measured is affected by underlying health care disparities, 3) meet statistical reliability and representation standards, and 4) show differences in performance across subgroups.

Selecting social risk factors to use in stratification

Social risk factors are the wide array of non-clinical drivers of health known to negatively impact patient outcomes. These include factors such as socioeconomic status, housing availability, and nutrition (among others). CMS recognizes the limited availability of social risk data to use in stratification as a challenge. The agency names different sources of data that can be used to identify social risk, including patient-reported data, CMS administrative claims, area-based indicators of social risk, and imputed data sources.

Identifying meaningful performance differences

CMS proposes different approaches to identify differences in performance for stratified results. One potential approach is ordering health care providers in a ranked system based on their performance on disparity measures to quickly allow comparison of performance with that of similar health care providers. Another potential approach is benchmarking or comparing individual results to state or national averages.

Reporting disparity measures

CMS discusses different approaches by which stratified measure results can be reported. The agency cites that confidential reporting, or reporting results privately to health care providers, is generally used for new programs or new measures to give providers an opportunity to become more familiar with calculation methods and to improve before wider reporting is implemented. Measure results can also be publicly reported to provide all stakeholders with important

information on provider quality. Public reporting relies on market forces to incentivize providers to improve and become more competitive in their markets without directly influencing payment from Medicare.

Comment

The Commission supports CMS's overall efforts to measure and report health care disparities by stratifying quality measure results for different subgroups of beneficiaries. We recognize that optimal health outcomes can be adversely affected by social risk factors. The Commission has traditionally focused on modifying payment systems to incentivize health care providers and payers (e.g., Medicare Advantage plans) to deliver high-quality care in the most efficient manner. While strong incentives for achieving value-based care objectives are critical, it is also important to apply such incentives fairly—that is, to recognize when these incentives can undermine access to care for beneficiaries. The Commission's recent work to account for differences in patients' social risk factors in quality payment programs and revisit payment for safety-net providers aims to improve incentives to deliver high-quality and efficient care. In the past, we have highlighted some disparities in care when we have identified them in our payment adequacy analyses. Moving forward, the Commission plans to more deliberately incorporate analysis by social risk factors, in particular income and race/ethnicity, into our payment adequacy and other analyses.

Over the past several years, the Commission has recommended redesigned value incentive programs that incorporate peer grouping for hospitals, Medicare Advantage plans, and skilled nursing facilities.[6] Rather than adjusting performance measures for patients' social risk factors, which can mask disparities in performance, these programs would make adjustments to payments based on a provider's performance compared with its peers. With peer grouping, each provider's performance is compared with providers with similar mixes of patients (that is, its "peers") to determine rewards or penalties based on performance. A provider would earn points based on its performance relative to national performance scales, but how those points are converted to incentive payments would vary by peer group, with larger multipliers (i.e., the payment adjustment per point) for peer groups with higher shares of beneficiaries at high social risk.

Selecting social risk factors to use in stratification

In our modeling of value incentive programs, we concluded that there is a need for better measures of patient social risk than are currently available.[7] The National Academies of Sciences, Engineering, and Medicine (NASEM) outlined considerations to determine whether a

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[6] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[7] Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

social risk factor (measure) should be accounted for in a Medicare quality payment program.[8] The social risk factor should have a *conceptual* relationship with the outcome of interest (that is, there should be a reasonable hypothesis positing how the social risk factors could affect a Medicare beneficiary's health outcome) and an *empirical* association with outcome measures (that is, there should be verifiable evidence of an association between the social risk factor and the outcome of interest).

Medicare beneficiaries who are disabled or low income are eligible to concurrently enroll in Medicaid. In our various value incentive program models, we tested a share of a provider's patients who were fully dually eligible for Medicare and Medicaid as a measure of social risk because there is a conceptual relationship between dual eligibility and our outcomes of interest. There is a clear and established relationship between poverty, socioeconomic status, and health outcomes—including increased risk for disease and premature death.

Although there are many reasons to use dual eligibility as proxy for beneficiary social risk, we recognize it is an imperfect measure. One drawback is that Medicaid eligibility requirements and benefits vary across states. Also, dual eligibility may be too narrow because it reflects a beneficiary's income but does not directly reflect other social risks, like food insecurity and limited access to transportation.

In the Commission's recent work to identify safety-net hospitals we expanded our definition of "low-income" as a proxy for beneficiary social risk.[9] In this work, we defined "low-income" beneficiaries as those who are eligible for full or partial Medicaid benefits or receive the Part D low-income subsidy (LIS). Expanding the definition of "low-income" to include all LIS beneficiaries helps to reduce the impact of variation in state Medicaid policies. This expanded definition includes beneficiaries who do not qualify for Medicaid benefits in their states but who do qualify for the LIS based on having limited assets and an income below 150 percent of the federal poverty level. In our hospital safety-net work, we referred to this collective population as "LIS beneficiaries" because those who receive full or partial Medicaid benefits automatically receive the LIS. Compared to the non-LIS Medicare population, LIS beneficiaries have relatively low incomes and differ in other regards, including being twice as likely to be Black or Hispanic and three times as likely to be disabled. The Commission intends to continue to explore improvements to our definition of "low-income" as a proxy for beneficiary social risk.

The Commission also recognizes that another approach to capture beneficiary social risk would be to use area-level measures of social risk.[10] We encourage CMS to test various area-level measures for their potential to account for differences accurately across providers in the social risk of their patient populations. More research is needed to understand the accuracy of any area-

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[8] National Academies of Sciences, Engineering, and Medicine. 2016. *Accounting for social risk factors in Medicare payment: Identifying social risk factors*. Washington, DC: The National Academies Press.
[9] Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. (Forthcoming June 2022)
[10] Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

level measure for Medicare beneficiaries compared with the gold standard of person-reported information.

Identifying meaningful performance differences

The Commission encourages CMS to report stratified quality measure results that are reliable, meaning that they reflect true differences in performance and are not attributable to random variation. Key steps for CMS include defining the reliability standard for measure results and selecting the strategies to ensure reliable measure results for as many providers as possible.

A high reliability standard should be used to determine the minimum number of observations required for a provider's performance to be stratified and reported. For providers with low patient volume, establishing reliable measure results is problematic because they do not have enough observations to ensure that the measure detects signal (actual performance) rather than noise (random variation). Unreliable measure results can lead to erroneous conclusions about a provider's performance: A low-volume provider can appear to have unusually good or poor performance when in fact its performance is not statistically different from the average.[11] In our illustrative modeling of a value incentive program for skilled nursing facilities, we used a reliability standard of 0.7, meaning that 70 percent of the variance in a measure's results was attributable to actual performance differences such that providers can be differentiated.[12]

Setting a minimum case count to ensure reliability inevitably means excluding some providers from the quality measurement program. One way to include as many providers as possible is to pool data across years, allowing a performance measure to be calculated for many small providers that would otherwise be excluded. Such pooling is consistent with other quality payment program designs and measures. For example, Medicare's Hospital Readmissions Reduction Program uses three years of performance data to calculate readmission results. Blending performance across years also encourages sustained high quality. However, pooling data across years could dampen a provider's drive to improve if their recent better results are blended with older, poorer performance. In such a case, the provider's improved performance would not be fully recognized in its incentive payment for several years. To counter this disincentive, CMS could consider weighting the more recent years more heavily. CMS could also pool data across years only for low-volume providers, while reporting just the most recent year's performance for providers that meet a minimum count in a single year.

Reporting disparity measures

The Commission supports moving to publicly reporting stratified measure results. Publicly reporting Medicare quality information has two main objectives. The first is to increase the accountability of health care providers by offering patients, payers, and purchasers a more informed basis on which to hold providers accountable (e.g., directly through purchasing and

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[11] Garrett, B., C. Carter, and D. Wissoker. 2021. Evaluation of the reliability of Medicare spending per beneficiary for post-acute care. *Medical Care* 59, no. 8 (August 1): 721–726.

[12] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

treatment decisions). The second objective is to maintain standards and stimulate improvements in the quality of care through economic competition (reputation and increased market share) and by appeals to health care professionals' desire to do a good job.[13] The Commission also contends that public reporting should enable comparisons of individual providers with state and national averages to give consumers meaningful reference points.

Changes to the SNF value-based purchasing (VBP) program

The CAA, 2021, allows the Secretary to add up to nine additional measures to the SNF VBP program. The additional measures may include measures of functional status, patient safety, care coordination, or patient experience. CMS proposes to add three measures to the VBP program. For FY 2026, it proposes to add rates of infections requiring hospitalization and total nursing hours per resident day. For FY 2027, it proposes to add rates of discharge to the community. CMS solicits comments on adding a measure of nurse staffing turnover (and, if so, if there should be a composite measure of the staffing level and turnover) and COVID-19 vaccination rates among staff to the VBP program in the future. CMS also seeks comments on the minimum stay counts for each measure to ensure reliable results and an approach to validate the performance measure data.

Comment

The Commission's June 2021 report to the Congress identified fundamental flaws in the design of the SNF VBP program (much of which is specified in statute and would require congressional action to correct) and recommended that a replacement SNF value incentive program (VIP) be implemented as soon as possible.[14] Most relevant to the proposed rule:

- the performance measure set—the measures should be population-based and tied to outcomes, patient experience, and resource use; and
- strategies to ensure reliable results should reflect performance, not random variation.

Expanding the measures included in the VBP program

The Commission supports the measures proposed for inclusion in the VBP. Although staffing level is not an outcome measure, it is tied to multiple outcomes (such as hospitalizations, pressure ulcers, emergency department use, and COVID-19 infection rates and deaths), and therefore we contend that it is a good measure to include in the VBP.[15] The Commission

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[13] Marshall, M. N., P. G. Shekelle, H. T. Davies, et al. 2003. Public reporting on quality in the United States and the United Kingdom. *Health Affairs* 22, no. 3 (May–June): 134–148.

[14] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery System*. Washington, DC: MedPAC.

[15] Among the extensive literature on the relationship between staffing levels and quality measures are the following recent articles: Konetzka, T., E. White, A. Pralea, et. al. 2021. A systematic review of long-term care facility characteristics associated with COVID-19 outcomes. *Journal of the American Geriatric Society* 69 (10): 2766–2777; B. Yang, M. Carter, A. Trinkoff, et al. 2021. Nurse staffing and skill mix patterns in relation to resident care outcomes in U.S. nursing homes. *Journal of the American Medical Directors Association* 22 (5):1081–1087;

supported including the infection measure in the SNF QRP and supports its inclusion in the SNF VBP. We also support including a measure of discharge to community—we included one in our recommended SNF VIP design. However, we encourage CMS to include in its measure calculation those nursing home residents who are discharged back to the same nursing home. For these beneficiaries, the nursing home is effectively their community.

Regarding possible future measures, the Commission supports the inclusion of a staff turnover measure because it gauges a complementary dimension of a facility's quality. While staffing levels measure the amount of direct care provided to residents, a turnover measure will indicate the continuity of care in a facility. Turnover rates have been positively associated with rehospitalization rates, emergency department visits, and infection rates.[16] Because the two staffing measures capture different dimensions, the Commission supports including both measures in a VBP program. If a composite measure were used, it would reduce the contribution of staffing in assessing a provider's performance (assuming equal weighting of the measures).

The Commission also supports the addition of the CoreQ patient experience measures to the VBP, consistent with our standing principle that quality measurement should include measures of patient experience. While CMS has not proposed doing so, we would also support adding Medicare spending per beneficiary (MSPB), a measure of resource use, to the VBP. MSPB is currently publicly reported and would require no additional data collection or calculation. This measure meets the Commission's quality principle that VBP measures should include a measure of resource use.

Minimum stay counts

Minimum stay counts help ensure that measure results are reliable—that is, they distinguish performance across providers. When measures are unreliable, the performance of one provider may appear to be different from another provider when in fact the sampling error around the estimate is so large that their performances are not statistically different from each other. Especially when tied to payment, measures should accurately reflect performance, not random variation.

In its June 2021 report, the Commission identified the minimum counts CMS uses to ensure reliable measures as a key shortcoming of the current design. Unfortunately, CMS's proposed rule does not correct this flaw, although CMS has the authority to do so. The minimum count currently used (and proposed to meet the PPACA requirement for a minimum volume for each

Gorges, R. and T. Konetzka. 2020. Staffing levels and COVID-19 cases and outbreaks in U.S. nursing homes. Journal of the American Geriatric Society 68(11): 2462–2466; R. Backhaus, H. Verbeek, R. van Rossum, et. al. 2013. Nursing staffing impact on quality of care in nursing homes: A systematic review of longitudinal studies *Journal of the American Medical Directors Association* 15(6): 383–393.

[16] Gandhi, A., H. Yu, and D. Grabowski. 2021. High nursing staff turnover in nursing homes offers important quality information. *Health Affairs*. 40 (3): 384-391; Loomer, L., D. Grabowski, H. Yu, et. al. 2021. Association between nursing home staff turnover and infection control citations. *Health Services Research* 57 (2): 322–332; Trinkoff, A., K. Han, C. Storr, et al. 2013. Turnover, staffing, skill mix, and resident outcomes in a national sample of U.S. nursing homes. *Journal of Nursing Administration* 43 (12): 630-636; Q. Zheng, C. Williams, E. Shulman, et. al. 2022. Association between staff turnover and nursing home quality–evidence from payroll-based journal data. *Journal of the American Geriatrics Society.* 1–9.

measure) is too low to ensure reliable measures. The Commission urges CMS to increase the minimum counts to a level that is sufficient to meet a commonly used standard of reliability (0.7, meaning 70 percent of the variation is explained by differences in performance and 30 percent is attributed to random variance). In our work, we found that minimum counts of 60 were needed for reliable results for the measures we included in our SNF VIP design (readmissions, successful discharge to the community, and Medicare spending per beneficiary).

The Commission appreciates that there is a tradeoff between achieving reliable results and driving quality improvement in as many providers as possible. One way to expand the number of SNFs meeting this higher reliability standard is to include multiple years in the performance period. More recent years could be weighted more heavily than earlier years. We urge CMS to consider tallying volume over multiple years to include as many providers in the VBP as possible. In our work, pooling data over 3 years resulted in the exclusion of only 10 percent of providers.

Validation of the SNF measures

The Commission supports the use of chart review to validate the MDS data. Our work examining the consistency of the recording of the function items raised serious questions about the accuracy of this data.[17] The Commission also supports a mix of random and targeted selection of providers for validation. Possible targeting criteria include providers with: abnormal patterns in the reported data, large changes over time or since a change in ownership, uniformly recorded patient assessment items regardless of patient characteristics (such as the reporting of low function scores), and an unusually high use of "activity did not occur" codes (which systematically are recoded as most dependent and receive higher payments). Because some patient assessment items (such as function and cognition scores, comorbidities, and depression) are used to assign patients to case-mix groups, the accuracy of these data has implications for program payments and beneficiary cost sharing.

We appreciate the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission values the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of our comments, please feel free to contact James E. Mathews, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

Michael E. Chernew, Ph.D.

Chair

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[17] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.