



June 5, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1779–P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via <https://www.regulations.gov/commenton/CMS-2023-0048-0002>

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 2024 (CMS–1779–P, published April 10, 2023)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I am submitting comments on the notice of proposed rulemaking (NPRM) addressing payment for skilled nursing facilities (SNFs) in federal fiscal year (FY) 2024 (CMS–1779–P).

Founded in 1955, NASW is the largest membership organization of professional social workers in the United States, representing more than 110,000 social workers. We work to enhance the professional growth and development of our members, to create and maintain professional standards, and to advance sound social policies.

Social workers play an essential role in serving Medicare beneficiaries across an array of settings, including SNFs. SNF social workers are dedicated professionals whose daily efforts enhance the quality of life and quality of care for residents. Yet, the efforts of these social workers and other members of SNF teams are hampered by daunting systemic challenges, some of which are addressed in these comments.

NASW's comments address the following sections of the NPRM:

- SNF Quality Reporting Program (QRP)—Section VI
- SNF Value-Based Purchasing Program (VBP)—Section VII
- civil money penalties (CMPs)—Section VIII

- impact of the Patient Driven Payment Model (PDPM) on beneficiary access to therapy services in SNFs
- resident access to mental health services provided by independent clinical social workers under Medicare Part B

SNF QRP (Section VI)

Section VI.C: QRP Measure Proposals

SUBSECTION 1A—PROPOSED MODIFICATION OF THE COVID-19 VACCINATION COVERAGE AMONG HEALTHCARE PERSONNEL (HCP) MEASURE BEGINNING WITH THE FY 2025 SNF QRP

NASW appreciates CMS’s proposal to modify the COVID–19 Vaccination Coverage among HCP measure beginning with the FY 2025 SNF QRP in two ways: (1) by replacing the term “complete vaccination course” with the term “up to date” in the vaccination definition and (2) by specifying the time frames within which one is considered up to date with recommended COVID–19 vaccines, including booster doses. Given that most SNF residents are at high risk for poor outcomes from COVID, however, we believe vaccination should be mandated for all SNF HCP (as defined in the NPRM). Moreover, we are concerned about the validity of any COVID-19 vaccination measure based on data that are self-reported by SNFs. We encourage CMS to develop data sources beyond self-reported data. Alternately, we recommend that CMS develop and implement auditing and penalty systems to detect and respond to inaccurate or falsified data.

SUBSECTION 1B—PROPOSED ADOPTION OF THE DISCHARGE FUNCTION SCORE (DC FUNCTION) MEASURE BEGINNING WITH THE FY 2025 SNF QRP

NASW recommends that CMS withdraw its proposal to adopt the DC Function measure as part of the SNF QRP beginning in federal FY 2025. We are concerned that the proposed measure is based exclusively on self-reported resident assessment (MDS) data, which independent research has determined are not accurate assessments of SNF performance.^{1,2}

Moreover, the measure calculates the percentage of residents “who meet or exceed an expected discharge function score” (p. 21338)—a clear focus on improvement. Although the preamble to the NPRM includes limited language about “maintenance” of function and the

¹ Williams, C., White, A., Muma, A., & Hadden, L. (2013, November 20–24). *Nursing Home Compare: The first four years of the five-star quality rating system* [Conference session]. Gerontological Society of America Annual Scientific Meeting, New Orleans, LA, United States. <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/2013-The-First-Four-Years-of-Five-Star.pdf> [Data are from slides 13 and 16]

² Edelman, T. (2015). *Changes to Nursing Home Compare and the five star quality rating system*. Center for Medicare Advocacy. <https://medicareadvocacy.org/changes-to-nursing-home-compare-and-the-five-star-quality-rating-system/>

Jimmo v. Sebelius settlement^{3,4} clarified that Medicare covers SNF services to maintain function or to prevent or slow deterioration from a beneficiary's condition, CMS has proposed no comparable measure for maintenance coverage. Thus, incorporation of the DC Function measure in the QRP would incentivize SNFs to forgo provision of maintenance services to Medicare beneficiaries. It could even encourage SNFs to favor admission of people whom they assess to have potential for improvement and deny admission to individuals who need SNF services to maintain function or to prevent or slow decline.

Another unintended consequence of the DC Function measure could be denial of SNF services to beneficiaries enrolled in Medicare Advantage (MA) plans. Research has found that MA enrollees are less likely to receive SNF or inpatient rehabilitation facility (IRF) services following hospitalization than are beneficiaries enrolled in original (fee-for service, or FFS) Medicare;⁵ a recent government report raised concerns that MA plans had inappropriately denied beneficiaries' access to inpatient postacute rehabilitation, even though the requests met rules for both Medicare coverage and MA billing.⁶ Given this trend, NASW is concerned if CMS were to implement a DC Function score only in SNFs and IRFs,⁷ as proposed, MA plans would be able circumvent measurements of quality by approving only home health care for beneficiaries with complex conditions and limited potential for improvement, even if SNF or IRF rehabilitation would be more appropriate.

The comments on this subsection also apply to Section VI.F, Subsection 2—Proposed Reporting Schedule for MDS Assessment Data for the DC Function Score Measure Beginning with the FY 2025 SNF QRP.

SUBSECTION 2A—PROPOSED ADOPTION OF THE COREQ: SHORT STAY DISCHARGE (COREQ: SS DC) MEASURE (NQF #2614) BEGINNING WITH THE FY 2026 SNF QRP

NASW strongly opposes CMS's proposal to adopt the CoreQ SS DC measure as part of the SNF QRP beginning in federal FY 2026. As CMS is aware, the measure was developed by the American Health Care Association. This fact alone should give one pause: Development of a satisfaction measure by the primary trade association of the nursing home industry is hardly a set-up for objectivity. This central concern notwithstanding, NASW opposes CMS's proposed adoption of the CoreQ SS DC measure for multiple reasons:

³ *Jimmo v. Sebelius*, Civil Action No. 5:11-CV-17-CR (D. Vt. Jan. 24, 2013).

⁴ Centers for Medicare & Medicaid Services. (2023). *Jimmo settlement*. U.S. Department of Health and Human Services. <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>

⁵ Kumar, A., Rahman, M., Trivedi, A. N., Resnik L., Gozalo, P., & Mor, V. (2018). Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLOS Medicine*, 15(6), e1002592. <https://doi.org/10.1371/journal.pmed.1002592>

⁶ Office of the Inspector General. (2022). *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care* (OEI-09-18-00260). U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp>

⁷ Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2024 and Updates to the IRF Quality Reporting Program, 88 Fed. Reg. 20950 (proposed Apr. 7, 2023) (to be codified at 42 C.F.R. pt. 412).

(1) *Lack of validity.* The four questions in the measure are too vague to provide useful information. For example, question 3 asks, “How would you rate the care you receive?” SNF care is multifaceted, encompassing multiple disciplines and components, including activities, dietary, nursing, social work, and therapies. Residents may have positive experiences in some aspects of their stay and negative experiences in others. Additionally, the criteria by which residents are supposed to evaluate staff are unclear (friendliness? responsiveness? professionalism? competency?), and the term “overall” implies a subset of factors and ratings that are not provided. Thus, the measure encourages each respondent to assign their own meaning to the question, thereby rendering their response useless to CMS and consumers. (The same problems apply to question 2, which asks residents to rate the staff “overall.”) Moreover, question 4 asks residents to rate how well their discharge needs were met. Many residents are not familiar with the requirements for discharge planning and how discharge services a SNF should provide. Without meaningful baseline information, residents cannot offer informed responses. In contrast, the federally developed Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures of resident and family experience are based on actual experiences and have been thoroughly tested for validity.

(2) *Skewed scoring and lack of objectivity.* Unlike a typical five-point Likert scale, which includes a neutral middle score, CoreQ SS DC includes the following choices: (1) poor, (2) average, (3) good, (4) very good, and (5) excellent. This design skews respondents toward positive responses. Similarly, if a respondent answers only three of the four questions, the CoreQ user manual instructs SNFs to add the answers to those three questions and divide by the sum three to infer a score for the fourth question, thereby calculating an overall score. Likewise, the SNF’s overall score is calculated by adding resident scores of three or more and then dividing the sum by the total number of questionnaires that are considered valid. In both situations, because “3” is a positive response—not a neutral, middle answer—this methodology overemphasizes positive responses. Similarly, the first question in CoreQ SS DC—“In recommending this facility to your friends and family, how would you rate it overall?” is problematic. Given that “recommend” connotes endorsement or preference, the first question suggests that residents should provide positive feedback to friends and family about a facility. The idea that a resident would recommend a facility while rating it as “poor” is both odd and confusing. Consequently, this question is biased toward positive reviews for the SNF.

As CMS notes, many facilities have voluntarily adopted CoreQ: SS DC and use it with ease. Yet, SNFs have historically used satisfaction surveys as marketing tools. CAHPS, on the other hand, is an objective and well-established tool.

(3) *Biased selection process and insufficient sample size.* The process for selecting discharged residents who receive the CoreQ SS DC questionnaire allows for significant provider gaming and likely skews the results. The questionnaire is sent

only to former SNF residents to be discharged to their homes or to assisted living, excluding the following individuals:

- (i) any resident who leaves against medical advice or is discharged to another SNF, a psychiatric facility, inpatient rehabilitation facility, long-term care hospital, or hospice—transitions that may reflect dissatisfaction with the care received at the SNF
- (ii) residents living with Alzheimer’s disease or other forms of dementia (some of whom could give meaningful opinions about their SNF stay)
- (iii) a family member (however a resident defines “family”) or representative of a former resident with dementia or of a resident who dies during their SNF stay
- (iv) a legal guardian of a resident under any circumstance

Moreover, although CMS would require facilities to use a CMS-approved CoreQ: SS DC survey vendor to administer the measure, CMS anticipates that SNFs would incur “an increase of 17.5 hours of staff time to assemble and submit the resident information files” to the vendor (p. 21410). Thus, each facility will determine which discharged residents to provide to the survey vendor and which to exclude. This process creates a loophole by which SNFs can exclude discharged residents whom they believe would respond negatively to a satisfaction survey. Furthermore, the CoreQ user manual considers 20 valid responses sufficient for a quality measure calculation, regardless of how many residents were discharged. A SNF’s ability to select which discharged residents receive the survey compounds the concern of insufficient sample size.

- (4) *Lack of reliability.* NASW respectfully disagrees with CMS’s conclusion that reproduction of CoreQ: SS DC survey results indicates the measure’s reliability. Rather, we believe that the limited number of questions in the measure, the vagueness of the questions, and the inherent bias in the scale, the computation process, and the selection process increases the likelihood of repeated results. CAHPS, in contrast, has been thoroughly tested for reliability.

The preceding concerns are underscored by the fact that independent reviewers have not endorsed CoreQ: SS DC. On the contrary, in its April 2022 report on nursing homes, the National Academy of Sciences, Engineering, and Medicine committee wrote:

In parallel with federal and state efforts, the nursing home industry has developed and implemented its own measures of resident and family satisfaction. For example, CoreQ, endorsed by the American Health Care Association, has three versions: long-term care residents, long-term care family, and short-stay discharged patients [citations]. Each version consists of three or four general questions that focus less on rating the quality of resident experience and more on summative satisfaction ratings. Another example of an industry-developed tool is NRC Health’s My Inner View Customer Satisfaction Survey [citation]. Many nursing homes promote and advertise high scores from self-designed and administered surveys of their residents. However, consumer advocates and survey methodologists have raised concerns that item wording and the choice of response

formats may increase the tendency of respondents to provide socially appropriate response choices and thus provide only minimal variation in the scale [citations].⁸

Given these concerns, the Committee elected not to endorse CoreQ: SS DC, instead recommending that CMS add the CAHPS measures of resident and family experience to the *Care Compare* website (recommendation 6A, p. 511). NASW seconds this recommendation and urges CMS to withdraw its proposal to adopt CoreQ: SS DC. We also urge CMS to require that SNFs use random sampling rather than allowing facilities to select former residents who will be surveyed. Lastly, we note that surveys will need to be conducted in person with many former SNF residents because of beneficiary changes in cognition, hearing, and vision.

The comments on this subsection also apply to Section VI.F, Subsection 3—Proposed Method of Data Submission and Reporting Schedule for the CoreQ: SS DC Measure Beginning with the FY 2026 SNF QRP.

SUBSECTION 2B—PROPOSED ADOPTION OF THE COVID-19 VACCINE: PERCENT OF PATIENTS/RESIDENTS WHO ARE UP TO DATE MEASURE BEGINNING WITH THE FY 2026 SNF QRP

NASW supports CMS's proposal to adopt this measure beginning with the FY 2026 SNF QRP. Vaccination remains an integral strategy to reduce COVID transmission and severity among facility residents. However, we are concerned that this measure is based on SNF self-reported MDS data. We encourage CMS to develop other data sources—or, alternately, to develop and implement auditing and penalty systems for inaccurate or falsified data. Likewise, we support CMS's proposal to begin displaying these data on Care Compare as soon as technically feasible (per Section VI.F, Subsection 4 of this NPRM— Proposed Public Reporting of the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning with the FY 2026 SNF QRP).

These comments also apply to Section VI.F, Subsection 4—Proposed Reporting Schedule for the Data Submission of MDS Assessment Data for the COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date Measure Beginning with the FY 2026 SNF QRP.

Section VI.D. Principles for Selecting and Prioritizing SNF QRP Quality Measures and Concepts Under Consideration for Future Years—Request for Information (RFI)

SUBSECTION 2—GUIDING PRINCIPLES FOR SELECTING AND PRIORITIZING MEASURES

As noted previously, NASW encourages CMS to develop data sources beyond SNF self-reported data, including data from the Minimum Data Set (MDS). Such data are subject to self-reporting

⁸ National Academies of Sciences, Engineering, and Medicine. (2022). *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*. National Academies Press. <https://doi.org/10.17226/26526> [Quote is from p. 111]

bias and have been found to be subject to inaccuracy.^{9,10} Instead, we recommend that CMS use Medicare claims data, when such data are available. Given the increasing number of beneficiaries enrolled in MA, we also recommend that CMS require MA plans to provide claims data. In resident-focused situations for which claims data are not available, we recommend that CMS develop and implement auditing and penalty systems for identifying and addressing inaccurate or falsified data.

To obtain meaningful data on SNF personnel, we support the use of CMS data such as the PBJ data submitted by SNFs on a quarterly basis. These data are partially audited and reviewed by CMS for accuracy. We urge CMS to focus on concrete structural measures currently available within the PBJ data. For example, facilities are required to report the number of paid hours provided by activity coordinators, medical directors, social workers, and therapists. However, because CMS is not examining the names of the individuals providing these services, SNFs can inflate reports regarding provision of these professional services.

SUBSECTION 3B—GAPS IN SNF QRP MEASURE SET AND POTENTIAL NEW MEASURES

NASW agrees with CMS that SNF measurement gaps exist in the following domains:

- cognitive function
- behavioral and mental health
- resident experience and resident satisfaction
- chronic conditions and pain management

As stated previously, we encourage CMS to develop data sources other than the MDS.

Section VI.E: Health Equity Update

NASW appreciates CMS's efforts to promote health equity, as defined in the following manner: the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.¹¹

We support CMS's efforts to develop ways to measure and mitigate health inequities.

⁹ U.S. Government Accountability Office. (2015). *Nursing home quality: CMS should continue to improve data and oversight* (GAO-16-33). <https://www.gao.gov/products/gao-16-33>

¹⁰ Integra Med Analytics. (2020). *Underreporting in SNF quality measures*.

<https://www.nursinghomereporting.com/post/underreporting-in-nursing-home-quality-measures>

¹¹ 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, 87 Fed. Reg. 22720 (proposed Apr. 15, 2023) (to be codified at 42 C.F.R. pt. 413).

Subsection VI.F: F. Form, Manner, and Timing of Data Submission Under the SNF QRP

SUBSECTION 5—PROPOSAL TO INCREASE THE SNF QRP DATA COMPLETION THRESHOLDS FOR MDS DATA ITEMS BEGINNING WITH THE FY 2026 SNF QRP

CMS has proposed that, beginning with the FY 2026 SNF QRP, SNFs would be required to report 100 percent of the required quality measure data and standardized patient/resident assessment data collected using the MDS on at least 90 percent of the assessments they submit through the CMS-designated submission system. NASW urges CMS to require that 100 percent of the quality data be reported on 100 percent of the assessments. Although the proposed 90 percent requirement is an improvement as compared to the current 80 percent threshold, it would still allow omission of MDS data that could be unfavorable to facilities.

SNF VBP (Section VII)

Section VII.B: SNF VBP Program Measures

SUBSECTION 4B—PROPOSAL TO ADOPT THE TOTAL NURSING STAFF TURNOVER MEASURE BEGINNING WITH THE FY 2026 SNF VBP PROGRAM YEAR

NASW strongly supports CMS's proposal to incorporate the Total Nursing Staff Turnover measure, based on CMS's Payroll Based Journal (PBJ) system, in the SNF VBP beginning in federal FY 2026. We also support the incorporation of such information on the Care Compare website. As CMS notes in the NPRM and research has demonstrated,¹² staff turnover decreases the quality of care for residents. At the same time, we encourage CMS to consider adding or substituting a measure of retention, which would incentivize positive behavior by facilities. We further recommend that payment incentives be granted only to SNFs with the lowest turnover or highest retention levels.

SUBSECTION 2C—PROPOSAL TO ADOPT THE PERCENT OF RESIDENTS EXPERIENCING ONE OR MORE FALLS WITH MAJOR INJURY (LONG-STAY) MEASURE BEGINNING WITH THE FY 2027 SNF VBP PROGRAM YEAR

Between 1999 and 2020, death rates from falls increased exponentially for people 65 years and older.¹³ Therefore, NASW strongly supports the development of a SNF VBP measure for falls with major injuries. We do not support the use of MDS data for reporting falls, however; research has found not only that the MDS understates resident falls, but also that correlations between claims-based falls rates and both quality measure star ratings and overall ratings are

¹² Zheng, Q., Williams, C. S., Shulman, E. T., & White, A. J. (2022). Association between staff turnover and SNF quality – evidence from payroll-based journal data. *Journal of the American Geriatrics Society*, 70(9), 2508–2016. <https://doi.org/10.1111/jgs.17843>

¹³ National Center for Health Statistics. (2022, September 23). QuickStats: Death rates from unintentional falls among persons aged ≥65 years, by age group — National Vital Statistics System, United States, 1999–2020. *NCHS: A Blog of the National Center for Health Statistics*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. <https://blogs.cdc.gov/nchs/2022/09/23/6608/>

weak.¹⁴ Instead, we encourage CMS to develop a falls measure based on Medicare claims data. (Were CMS to use MDS data for the VBP program, systems for auditing and penalizing false or inaccurate data would need to be developed and implemented.) Moreover, we urge CMS to require MA plans to report claims data for its enrollees receiving SNF residents in the future.

SUBSECTION 2D—PROPOSAL TO ADOPT THE DC FUNCTION SCORE MEASURE BEGINNING WITH THE FY 2027 SNF VBP PROGRAM YEAR

Our comments regarding incorporation of this measure in the QRP also apply to the VBP.

SUBSECTION 2E—PROPOSAL TO ADOPT THE NUMBER OF HOSPITALIZATIONS PER 1,000 LONG-STAY RESIDENT DAYS MEASURE BEGINNING WITH THE FY 2027 SNF VBP PROGRAM YEAR

NASW supports CMS's goal of incorporating a measure of hospitalizations for long-stay residents. However, we are concerned that the proposed measure excludes residents enrolled in Medicare Part C (Medicare Advantage), thereby excluding half of all beneficiaries nationwide.¹⁵

Section VII.E: SNF VBP Performance Scoring Methodology

SUBSECTION 4—PROPOSAL TO INCORPORATE HEALTH EQUITY INTO THE SNF VBP PROGRAM SCORING METHODOLOGY BEGINNING WITH THE FY 2027 PROGRAM YEAR

NASW supports CMS's proposed Health Equity Adjustment (HEA), which would reward SNFs that serve at least 20 percent of residents who are dually eligible for Medicare and Medicaid. We encourage CMS to limit this bonus to SNFs in the top 20 percent, not (as proposed) to those in the top third. At the same time, we urge CMS to increase scrutiny on how SNFs that are eligible for an HEA spend their current Medicare and Medicaid dollars. This dual approach would both incentivize more equitable access and help CMS understand the problems facing facilities that serve large proportions of dually eligible beneficiaries.

Furthermore, given that dual eligibility is but one indicator of barriers to SNF access, we encourage CMS to explore other strategies that would incentivize facilities to serve residents from underresourced communities. For example, NASW urges CMS to make facility-level data on resident race and ethnicity available to the public. Such public access would enable researchers, policymakers, and advocates to address racial and ethnic disparities in care rather than having to rely on geographic assumptions.

¹⁴ Sanghav, P., Pan, S., & Caudry, D. (2019). Assessment of nursing home reporting of major injury falls for quality measurement on nursing home compare. *Health Services Research*, 55(2), 201–210. <https://doi.org/10.1111/1475-6773.13247>

¹⁵ Fuglesten Biniek, J., Freed, M., Damico, A., & Neuman, T. (2023). *Half of all eligible Medicare beneficiaries are now enrolled in private Medicare Advantage plans*. KFF. <https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/>

SUBSECTION 5D—DEVELOPMENT OF DOMAINS AND DOMAIN WEIGHTING FOR INCLUSION IN THE SNF VBP PROGRAM

NASW urges CMS to increase the weighting for structural measures and those based on claims data and reduce all the weighting for MDS-based measures.

Section VII.G: Proposal to Update the Validation Process for the SNF VBP Program

NASW is concerned about CMS’s proposal to adopt a “validation process that applies to SNF VBP measures that are calculated using MDS data” (p. 21398). We agree that validating measures that use MDS data makes sense. However, such validation should occur before CMS incorporates any MDS-based measures in the SNF VBP, not after the adoption of such measures. Development and implementation of auditing and penalty systems for inaccurate and incomplete MDS data are also essential.

SNF CMPs (Section VIII)

NASW opposes CMS’s proposal to create a “constructive waiver” process for SNFs in relation to CMPs. Under such a process—which was proposed by the Trump Administration in 2019 but not finalized¹⁶—CMS would grant an automatic 35 percent reduction in the CMP to any SNF that fails to state in writing it is not appealing deficiencies and the corresponding CMPs. In so doing, CMS would alter, without a compelling rationale, a policy that has been in place for two decades.

CMS’s rationale for reviving this process is identical to that offered by the Trump Administration: the fact that relatively few SNFs have failed to submit written statements indicating that they were waiving hearings for CMPs. Yet, CMS does not explain why the comparatively small number of facilities that fail to submit written waivers should receive an automatic 35 percent reduction in their CMPs. Although federal rules (42 C.F.R. § 488.30) authorizes CMS to settle a CMP case with a SNF for 35 percent (or more) at any time, this settlement authority does not support an automatic 35 percent reduction in a CMP for a facility that fails to submit a written waiver of a hearing.

Moreover, the point of issuing penalties to SNFs for violations of federal regulation is to deter poor service delivery. Yet, federal sanctions have not been used effectively as a means for correcting repeated facility violations. CMS generally limits CMPs to deficiencies that are cited as actual harm or immediate jeopardy—problematic classifications applied to fewer than 4

¹⁶ Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Regulatory Provisions To Promote Efficiency, and Transparency, 84 Fed. Reg. 34737 (proposed Jul. 18, 2019) (to be codified at 42 C.F.R. pts. 410, 482, 483, 485 & 488).

percent of all deficiencies.^{17,18} SNFs with serious violations that cause harm or jeopardy including deaths are often not given penalties—or the penalties are so minimal that the enforcement does not result in compliance, especially in facility chains.¹⁹ The most effective penalty of placing a hold on payment for new admissions is rarely used. Substandard SNFs, even those with a years-long pattern of poor service delivery, are seldom terminated from the Medicare program. Moreover, state survey agencies often fail to report substantiated abuse cases to local law enforcement, and CMS does not record and track many of these incidents in its automated tracking system.²⁰ Given these factors, a “constructive waiver” of 35 percent of the CMP would decrease even further the consequences for harm caused to residents while saving millions of dollars for SNFs.

Impact of PDPM on beneficiary access to therapy services in SNFs

NASW remains concerned that PDPM limits beneficiaries’ access to occupational therapy (OT), physical therapy (PT), and speech–language pathology (SLP) services in SNFs—a concern we expressed in coalition letters in 2019²¹ and 2021.²² In 2018, CMS agreed with advocates’ concerns that the financial incentives of PDPM could prompt facilities to reduce needed therapy services and established certain safeguards accordingly.²³ Only one year later, however, CMS loosened the requirements for therapy provision in SNFs, thereby incentivizing facilities to

¹⁷ Centers for Medicare & Medicaid Services. (2015). *Nursing home data compendium 2015 edition*. U.S. Department of Health and Human Services. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf [Data are from Figure 2.2.e, p. 48]

¹⁸ Center for Medicare & Advocacy & Long Term Care Community Coalition. (2017–2023). *Elder justice newsletter: What “no harm” really means for residents*. <https://medicareadvocacy.org/newsletter-elder-justice-what-no-harm-really-means-for-residents/>

¹⁹ Harrington, C., Stockton, J., & Hooper, S. (2014). The effects of regulation and litigation on a large for-profit nursing home chain. *Journal of Health Politics, Policy and Law*, 39(4), 781–809. <https://doi.org/10.1215/03616878-2743039>

²⁰ Office of the Inspector General. (2019). *Incidents of potential abuse and neglect at skilled nursing facilities were not always reported and investigated* (A-01-16-00509). U.S. Department of Health and Human Services. <https://oig.hhs.gov/oas/reports/region1/11600509.asp>

²¹ American Academy of Physical Medicine & Rehabilitation, American Congress of Rehabilitation Medicine, American Spinal Injury Association, California Advocates for Nursing Home Reform, Center for Elder Law & Justice, Center for Medicare Advocacy, Falling Forward Foundation, Justice in Aging, Long Term Care Community Coalition, Massachusetts Advocates for Nursing Home Reform, Our Mother’s Voice, Senior Citizens Law Office, National Association of Social Workers, & The National Consumer Voice for Quality Long-Term Care. (2019, June 18). *Joint comments on SNF rules, including important group therapy changes* [Response to CMS–1718–P]. <https://medicareadvocacy.org/joint-comments-on-snf-billing-quality-programs/>

²² Coalition to Preserve Rehabilitation. (2021, June 7). *Comments responding to CMS–1746–P*. <https://preserverehab.files.wordpress.com/2021/06/coalition-to-preserve-rehabilitation-comments-on-fy-22-snf-proposed-rule-6.7.21.pdf>

²³ Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Final Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program, 83 Fed. Reg. 39162 (Aug. 8, 2018) (codified at 42 C.F.R. pts. 411, 413, & 424).

maximize the use of group or concurrent therapy rather than individual therapy.²⁴ After the first year of PDPM implementation, CMS reported that therapy services provided to SNF residents had decreased by more than 30 percent, from 91 minutes per resident per day to 62 minutes per resident per day. Likewise, CMS reported that the use of group or concurrent therapy had increased from 1 percent of all SNF stays to 29 and 32 percent of SNF stays, respectively. CMS attributed these changes specifically to PDPM, not to the COVID-19 pandemic.²⁵ In contrast, CMS noted that PDPM had inadvertently resulted in payment increases of 5 percent to SNFs in the first year of its implementation. Yet, the problems with PDPM persist—and are not addressed in the current NPRM.

Consequently, NASW urges CMS to implement the following steps, consistent with 2021 recommendations from the Center for Medicare Advocacy:²⁶

- Analyze all resident discharge assessment data since PDPM and publicly report the findings.
- Add a mandatory financial penalty for SNFs that exceed the 25 percent cap on group or concurrent therapy, setting the penalty at an amount that exceeds the cost of compliance with the 25 percent cap.
- Identify SNFs that dramatically changed therapy services after PDPM implementation and direct state survey agencies to conduct surveys at those facilities to determine whether they violated CMS’s Requirements for Participation. Such surveys should address, at a minimum, the following topics: resident assessment and care planning, professional standards of quality, and provision of care and services. If survey agencies identify noncompliance, CMS should cite appropriate deficiencies and impose per-day civil money penalties that exceed the cost of compliance with the Requirements for Participation.
- Consider reinstating a requirement for multiple resident assessments (such as on days 14, 30, 60, and 90, as used in the prior reimbursement system, Resource Utilization Groups) in lieu of a single assessment on the fifth day of a resident’s stay (as now required under PDPM). Multiple MDS assessments would provide a more thorough and accurate depiction of each resident’s condition and SNF needs than a single fifth-day assessment, thereby promoting not accuracy in Medicare payments and in quality measures (to the extent such measures remain based on MDS data).

²⁴ 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 2020, 84 Fed. Reg. 38728 (Aug. 7, 2019) (codified at 42 C.F.R. pts. 409 & 413).

²⁵ Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022, 86 Fed. Reg. 19954 (proposed Apr. 15, 2021) (to be codified at 42 C.F.R. pts. 411, 413, & 489).

²⁶ Edelman, T. (2021, June 3). *Center comments on SNF reimbursement, FY 2022*. Center for Medicare Advocacy. <https://medicareadvocacy.org/center-comments-on-snf-reimbursement-fy-2022/>

Such actions would greatly enhance the likelihood that residents receive the OT, PT, and SLP services they need, whether for improvement or maintenance^{27,28}—and to which they are entitled under Medicare law.

Resident Access to Mental Health Services Provided by Independent Clinical Social Workers under Medicare Part B

NASW has been working with CMS and Congress for years to remove the restriction that prohibits beneficiaries who receive SNF services under Medicare Part A from accessing mental health services provided by independent clinical social workers under Medicare Part B. We appreciate the technical assistance CMS has provided to members of Congress on this issue. Although we continue to focus our efforts on legislative solutions to the problem, we call to CMS's attention the following recommendation from the 2022 NASEM nursing home study:

Recommendation 2D: To enhance the available expertise within a nursing home:

- Nursing home administrators, in consultation with their clinical staff, should establish consulting or employment relationships with *qualified licensed clinical social workers at the M.S.W. or Ph.D. level* [emphasis added], advanced practice registered nurses (APRNs), clinical psychologists, psychiatrists, pharmacists, and others for clinical consultation, staff training, and the improvement of care systems, as needed.
- The Centers for Medicare & Medicaid Services should create incentives for nursing homes to *hire qualified licensed clinical social workers at the M.S.W. or Ph.D. level as well as APRNs for clinical care* [emphasis added], including allowing Medicare billing and reimbursement for these services.²⁹

We appreciate CMS's consideration of this long-standing barrier to beneficiary mental health care.

Thank you for your consideration of NASW's comments. Please contact me at BBedney.nasw@socialworkers.org if you need additional information.

Sincerely,



Barbara Bedney, PhD, MSW
Chief of Programs

²⁷ Center for Medicare Advocacy. (n.d.). *Improvement standard and Jimmo news*. <https://medicareadvocacy.org/medicare-info/improvement-standard/>

²⁸ Centers for Medicare & Medicaid Services. (2023). *Jimmo settlement*. U.S. Department of Health and Human Services. <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>

²⁹ National Academies of Sciences, Engineering, and Medicine. (2022). *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*. National Academies Press. <https://doi.org/10.17226/26526> [Quote is from p. 512]