

**Leading Age Comments on 2022 MUC List Measures Proposed
for Home Health and Skilled Nursing Facilities**

(as submitted electronically to the National Quality Forum on December 7, 2022)

I. Home Health Quality Reporting program

a. MUC2022-085: Cross Setting Discharge Function Score

Comment: LeadingAge members support functional measures for the quality reporting program but do not support this measure for rulemaking. We feel the measure is too complicated, easy to game based upon perception of what function is “expected” (e.g., discharge goal) and difficult for home health staff to know where the gap is on their performance because there are so many function elements within a single score. For this reason, this measure would make it very hard for HHAs to identify what caused them to have a low score and how to improve on their performance, which surely must be a goal of a QRP. We also would want to make sure that HHAs are not inadvertently penalized because they provide maintenance care to clients, per the Jimmo v. Sebelius decision. These are often non-profit, mission-driven agencies. We think some clarification of the application of this measure to the maintenance population would be helpful. Overall, it is better to have individual function measures instead of an amalgamated measure that muddies the outcome and the path to improvement. For these reasons, we do not support this measure for rulemaking as written.

b. MUC2022-090: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

Comments: Overall, Home Health agencies support the goal of ensuring more clients receive preventative vaccines, such as COVID-19, but do not support this measure, as written, for inclusion in the HH QRP for a few reasons. First, it is really challenging for home health agencies to help clients access COVID vaccines because of the storage issues. Second, this measure is described as a process measure, but it doesn’t measure a provider process, it measures an outcome. A process would be what % of home health clients who weren’t up to date on their COVID-19 were offered one? This would differentiate home health agencies based upon their actions and as such, would be appropriate for QRP. As written, this measure does not assess a process or quality but merely a client’s status. This measure seeks to document how many home health clients in one quarter are up to date on their COVID-19 vaccinations. By only measuring one quarter, it merely represents a snapshot in time vs. a current state, which makes it less useful to consumers to make decisions. Whether or not a person decides to receive a vaccine is not a reflection of provider quality but instead may reflect issues of access, personal or cultural preferences. Third, this information is not currently collected via the OASIS assessment as finalized December 7th, 2022, although if this measure is added to QRP, we agree this would be the least burdensome way to collect this data. In the end, a home health client touches so many other health care settings and clinicians that are better suited to ensuring they are up-to-date on their COVID-19 vaccine and delivering the vaccine that we feel the application of this measure in the home health setting does not reflect an agencies quality of care delivered.

II. SNF QRP

a. MUC2022-092: COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

Comments: Overall, SNFs support the goal of ensuring more residents receive preventative vaccines, but do not support this measure for rulemaking as currently written. Uptake of a preventative vaccine is important information to share with consumers via Care Compare like the currently-tracked influenza and pneumococcal vaccines. We agree that collection of this data via MDS is more appropriate than the current NHSN reporting requirements. However, this data is not currently collected via either the current MDS 3.0 or its proposed replacement v. 1.18.11 so would need to be added. It is not clear based upon the available materials whether CMS's intent is to replace the required SNF NHSN reporting on resident vaccine status or if this would be duplicative. We would not support if this were additive.

We have the following concerns with the measure, as proposed:

- **Measure limited to short-stay FFS residents only:** The measure only looks at vaccine status among short stay residents, which does not reflect the entire resident population within most nursing homes, who serve short stay and long stay residents. In addition, given that the measure does not collect data on Medicare Advantage residents within the facility it does not provide consumers with complete information especially in regions of the country where 50%+ of residents are on MA and may even distort the picture of vaccination status. If the reason for this measure is resident safety and/or for consumer decision making purposes, then the status of all residents within the nursing home would be relevant regardless of duration or payer source.
- **Doesn't measure provider process but only resident behavior:** This measure is described as a process measure, but it doesn't measure a process, it measures an outcome. A process would be what % of short-stay Medicare A residents who weren't up to date on their COVID-19 were offered one? This would differentiate nursing homes based upon their actions and as such, would be appropriate for QRP. As written, this measure does not assess a process or quality but merely a resident's status. This measure seeks to document how many short-stay Medicare A residents in one quarter are up to date on their COVID-19 vaccinations. By only measuring one quarter, it merely represents a snapshot in time vs. a current state, which makes it less useful to consumers to make decisions. Whether or not a person decides to receive a vaccine is not a reflection of provider quality but instead may reflect issues of access, personal or cultural preferences. Regional variation has been documented by [KFF](#). Also, residents have the right to refuse a vaccine.

To improve the measure, CMS should consider: 1) adding a data element to the MDS on COVID-19 vaccine status and whether the facility offered the vaccine, if needed, to the resident and whether it was refused or accepted; 2) collect & report data on all nursing home residents; and 3) once modified as outlined above, have this measure replace the NHSN reporting requirement to prevent duplicate reporting.

b. MUC2022-086: Cross Setting Discharge Function Score

Comment: LeadingAge members support functional measures for the quality reporting program but do not support this measure for rulemaking. SNF members felt that this measure is too complicated, easy to game based upon perception of what function is “expected” and difficult for SNFs to know where the gap is on their performance because there are so many elements within a single score. For this reason, this measure would make it very hard for SNFs to identify what caused them to have a low score and how to improve on their performance, which surely must be a goal of a QRP. They have found considerable value in the Change in Mobility and Change in Self Care measures and believe overall it is better to have individual function measures instead of an amalgamated measure that muddies the outcome and the path to improvement.

III. SNF VBP

MUC2022-086: Cross Setting Discharge Function Score

Comment: LeadingAge members believe functional measures are important for determining the quality of SNF care provided but do not support this measure for rulemaking. First, this measure is not currently part of the SNF QRP, which provides the opportunity to further test and ensure adequate reporting prior to use it for VBP. Second, SNF members felt that this measure is too complicated, and yet easy to game based upon perception of what function is “expected.” Most importantly, because the measure represents an amalgamation of several, separate functions that a resident does/does not improve upon, it would be difficult for SNFs to identify what caused them to have a low score and how to improve on their performance. The ability for a provider to affect the measure is essential for a VBP measure. An alternate approach would be to add function measure(s) to the VBP such as adding the Change in Mobility and Change in Self Care measures, as members report value in these performance measures and the better reflect the impact the nursing home care is having on the individual’s function.

a. MUC2022-035: Percent of Residents Experiencing One or More Falls with Major Injury (Long-stay)

Comment: LeadingAge SNF members believe this measure requires some additional refinements prior to supporting its inclusion in the VBP. First, the measure look-back period should be shorter to incentivize improvement. Under the proposed definition to use a 275-day look-back, falls remain in the score for

12-18 months. These situations can reduce motivation for direct care staff to continue to make needed changes when they don't see the results of their efforts more quickly. We think the look back scans should be for a quarter. The data could be collected per quarter for an annual total but shouldn't report the same event multiple times. This approach allows the events to be captured but doesn't repeatedly penalize a SNF for the same event. In addition, since the measure speaks to major injury, we would ask CMS to consider excluding small bone fractures (e.g. finger, toe, etc.) from the definition of major injury. These can happen easily in a frail population and usually residents recover quickly from these situations with little impact on their function. Instead, we think this should be limited to major bone fractures.

b. MUC2022-099: SNF withing stay Potentially Preventable Readmissions Measure

- **Comment:** Overall, LeadingAge supports transition to this measure from the current SNF Readmission Measure. We appreciate the refinements to eliminate overlap with post-SNF discharge PPR measure in the QRP. One item for consideration for future refinement is to look at how to address individuals who may cycle back and forth to the hospital many times before the family or resident agrees to enter hospice care.

c. MUC2022-113: Number of Hospitalizations per 1,000 Long-Stay Resident Days

Comment: We have a couple of questions or items that should be considered before this measure is adopted for the SNF VBP. We want to understand why a measure on long-stay residents is being proposed for use in the Medicare VBP program, which is short-stay residents. Does the measure include risk-adjustment and what are the details of that? Will the risk-adjustment include individuals with long COVID who may be struggling with ongoing heart, lung and brain issues since contracting COVID. We think this should be considered in the risk adjustment, as it is not clear what the impacts may be. Under the denominator exclusions, it includes residents who were not in the nursing home for any reason during the episode including...days temporarily residing in the community. What circumstances might this include? Does it include long-stay residents who leave for the holidays? We think this measure requires more thought before moving it into the measure set for the SNF VBP.

d. MUC2022-126: Total Nursing Staff Turnover

Comment: LeadingAge understands the importance of a turnover measure but believes that the measure as written does not measure the right things and sets up unintended consequences that in a VBP would penalize a SNF for efforts to staff adequately to provide quality care. The current definition includes agency staff who play an important role in filling open positions within SNFs until a new person can be hired. These staff by virtue of their role are designed to

“turnover”. It is a quality action to bring in agency staff while SNFs search for permanent staff. The inclusion of agency staff presents an inaccurate picture of a SNFs staffing retention. It would be better to pull these staff out of the turnover measure and track agency use in a separate measure. This would present consumers and their families with a better view of how the SNF is staffed and by what type of staff - permanent vs. temporary.

In addition, the turnover definition counts nursing staff as no longer working at the nursing home if they do not work any hours for 60 consecutive days or more. This approach pulls in staff who remain employed with the organization but because of the following situations are defined as turnover: individuals on maternity leave or Family Medical Leave Act, foreign born staff who take extended vacation to return to their birth country to see family but who return to the same nursing home, seasonal workers such as college students who work on and off year-round during their school breaks, nursing students who work as CNAs while they attend school, and parents who may work during the school year but stay at home when their kids are off in the summer. Nursing staff who leave and return to the nursing home indicate committed staff and sound culture within the organization. In contrast, staff who just leave in high numbers tells a different story. Today’s workforce is looking for greater flexibility to meet the demands of their lives and to secure quality staff, SNFs must offer such schedule flexibilities to be competitive. The measure should be revised to either extend the number of consecutive days that the employee has no hours worked or the employee must show no hours worked in 2 or more quarters during a 12-month performance period. Due to these concerns, LeadingAge does not support the measure as written.