June 10, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Request for Information: Unleashing Prosperity Through Deregulation of the Medicare Program

Submitted via https://www.cms.gov/medicare-regulatory-relief-rfi

Dear Administrator Oz,

Thank you for the opportunity to submit comments via your request for information to streamline regulations and reduce administrative burdens on stakeholders participating in the Medicare program per Executive Order 14192. As the nation's largest association representing long term and post-acute care facilities, the American Health Care Association/National Center for Assisted Living (AHCA/NCAL) stands ready to work with the Trump Administration on rationalizing regulations, especially for nursing homes, to further advance quality. We applaud your efforts to ensure that requirements do not divert unnecessary time and resources away from patient care, create efficiencies, and encourage innovation.

AHCA/NCAL's more than 15,000 member facilities provide essential, life-affirming care to millions of individuals in America's nursing homes and other long term care facilities. From large to small, rural to urban, nursing homes are incredibly diverse but are equally passionate about serving seniors and individuals with disabilities, which they do in nearly every community in the country. Most nursing home residents rely on Medicare or Medicaid to cover their care; therefore, federal resources and regulations have a pivotal impact on providers and stakeholders. In order to continue to enhance this care and prepare for our nation's rapidly growing aging population, we must work together to advance bold and innovative solutions.

For decades, federal bureaucrats have piled on requirements, reporting, and enforcement, but these punitive policies and additional administrative tasks have failed to produce real change. Instead, we have an inconsistent and ineffective oversight system that does not drive quality improvement among nursing homes or enhance the quality of life for residents. What it does drive is highly qualified and dedicated caregivers out of or away from the long term care profession, contributing to our sector's ongoing workforce challenges. Stakeholders across the gamut are unsatisfied with the results, and policymakers and taxpayers aren't getting an optimal return on their investment.

AHCA/NCAL fully supports appropriate oversight, consumer transparency, and accountability of chronic poor performers to ensure the health and safety of our residents. However, we also believe there are many nursing home regulations and guidance that are duplicative, antiquated, confusing,

and inconsistent across various agencies as well as with other healthcare settings. AHCA's "Better Way" policy priorities for 2025 include Rationalizing Regulations. We have practical solutions that would create a more effective and balanced regulatory environment.

This does not mean compromising the quality of care long term care facilities provide—it means enhancing it. When we streamline regulations and guidance, reduce administrative burden, eliminate duplicative tasks, and harness new, innovative ideas, we have the potential to further a measurable impact and incredible experience for our residents. At the same time, rationalizing regulations can help recruit dedicated caregivers and empower seniors and their families with clear, useful information. It can also ensure accountability while creating government efficiencies. It's a win for everyone.

Therefore, per your request for information, we submit to you today several regulations, guidance, and actions that should be modified, repealed, or taken that would make a meaningful difference in advancing quality improvement in long term and post-acute care. Some of these recommended changes could be made immediately through sub-regulatory guidance or interim final rulemaking, and other changes are more suitable for formal notice of proposed rulemaking. They are outlined in the attached appendix. Ultimately, the regulatory changes we put forth today help put patients over paperwork, reduce redundancy, modernize care delivery, support workforce development, promote innovation, and better utilize precious taxpayer resources.

As an organization whose mission is to improve lives by delivering solutions for quality care, we appreciate that opportunity to share our solutions with you today. We welcome meeting with you and other CMS officials to discuss these proposals further. Together, we can improve the regulatory system to be efficient, consistent, and fair. For the sake of our nation's nursing home residents who deserve the utmost care and our nursing home staff who should be recognized and empowered, we appreciate your thoughtful consideration. Please do not hesitate to contact Holly Harmon, Senior Vice President of Quality, Regulatory & Clinical Services at hharmon@ahca.org to discuss further.

Sincerely,

Clifton J. Porter, II
AHCA/NCAL President & CEO

cc: HHS Secretary Robert F. Kennedy, Jr.

Encl.: Appendix: AHCA Response to "Unleashing Prosperity Through Deregulation of the Medicare Program" (Executive Order 14192) - Request for Information

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CREATING A MORE EFFICIENT HEALTHCARE SYSTEM

Risk-Based Surveys

AHCA Recommendation: Expand implementation of the Risk-Based Survey (RBS) process nationwide (via process/guidance update to LTC Survey Process Procedure Guide).

> **Recommendation A:** Implement the RBS process nationwide and expand its use to the top 20% of performing nursing homes.
>
> **Recommendation B:** Implement the RBS process nationwide for all nursing homes, other than Special Focus Facilities. This can be done by updating the LTC Survey Process Procedure Guide. This recommendation offers the most efficient use of CMS and SSA resources.

Rationale:

The RBS process focuses on critical areas of care and high-risk issues, making inspections more efficient and impactful. The RBS process delivers the same results as the standard survey, but in half the time and with half of surveyor resources. CMS has already piloted this process with favorable results. This data-driven approach allows regulatory resources to be better utilized, directing them toward facilities that require the most improvement while incentivizing quality performance.

- **Maintaining Accountability**: Since the RBS model allows surveyors to go into a full survey, if warranted, there is very little reason for the RBS approach not to be applied to a greater number of facilities (excluding SFF).
- **Benefits to Residents and Staff**: By reducing unnecessary survey disruptions in consistently compliant facilities, staff can focus more on direct resident care, reducing stress and enhancing job satisfaction. A more stable and predictable survey process may also improve staff retention.
- **Optimizing Resources and Incentivizing High Performance**: Expanding the use of this process to more top-performing facilities will further support effective use of oversight resources of State Survey Agencies and recognize facilities that have consistent and stable compliance, providing high-quality care.

Deemed Status

AHCA Recommendation: Allow nursing homes to utilize deemed status (via statute change).

Rationale:

Deemed status, a designation granted to healthcare facilities accredited by an approved accrediting organization, allows facilities to demonstrate compliance with federal standards through accreditation. Allowing nursing homes to utilize deemed status offers a pathway to greater government and provider efficiency and innovation without compromising care standards. Accrediting bodies approved by CMS apply rigorous standards that align with, or exceed, in some areas, CMS's Requirements of Participation.

- **Creating Government Efficiencies**: Allowing nursing homes to achieve deemed status eliminates redundant inspections, freeing CMS resources to focus on oversight of chronic poor-performing facilities and other priorities. The change would offer enhanced governmental efficiency through oversight.
- **Improving Quality**: Accreditation organizations promote a culture of continuous improvement by emphasizing evidence-based practices, regular self-assessment, and ongoing education. Deemed status motivates nursing homes to consistently meet high standards, fostering improved quality through continuous innovation and better resident outcomes.
- **Realigning Provider Resources to Care**: Nursing homes utilizing deemed status can allocate resources toward quality improvement initiatives instead of duplicative compliance processes that are not adding value. For CMS, significant administrative costs can be reduced by leveraging the robust evaluation processes of accrediting bodies.
- **Encouraging Innovation**: Deemed status encourages nursing homes to adopt innovative practices and technologies tailored to accreditation standards, which are often updated more rapidly to reflect advancements in healthcare.

Deemed status has proven successful in other healthcare settings, such as hospitals and other post-acute care settings. Extending this model to nursing homes provides consistency across healthcare delivery systems while maintaining accountability and fostering excellence.

Standard Survey Frequency

AHCA Recommendation: To be consistent with other healthcare settings: adjust nursing home standard survey frequency to not less frequently than once every 36 months (via statute change).

Rationale:

We recommend CMS revise the statute to change the mandatory survey frequency for nursing homes from the current interval (15 months after the date of the previous standard survey and the statewide average interval between standard surveys not to exceed 12 months) to not less

frequently than once every 36 months for facilities with a proven history of compliance (all facilities not on the Special Focus Facility [SFF] list).

The aim is to optimize resource allocation, reduce administrative burden on good-performing facilities, and align with CMS's and State Survey Agencies' (SSAs) capacity while maintaining the quality and safety of resident care.

- **Consistent with Other Medicare Healthcare Settings**: Other Medicare-certified healthcare settings, such as hospitals and home health, and hospice, follow a three-year survey cycle which would bring nursing homes more in line with these standards.
- **Resource Optimization for CMS**: The current 15-month requirement often strains CMS and SSA resources, leading to the current and chronic standard survey delays as well as an inconsistency across the country in survey oversight. A three-year cycle for compliant facilities aligns the frequency of surveys with CMS's and SSA operational capacity. Additionally, reducing the survey frequency for well-performing nursing homes allows CMS to reallocate resources toward monitoring facilities with poor compliance (e.g., SFFs) or in urgent need of assistance, improving overall oversight effectiveness.
- **Recognition for Good-Performing Nursing Homes**: Nursing homes consistently meeting compliance and quality standards should not be subjected to frequent surveys. Extending the interval rewards these facilities and encourages sustained high performance. Complaint and focus surveys would remain in place, providing CMS with the means to identify changes in performance.
- **Focus on High-Risk Facilities**: With fewer resources dedicated to frequent surveys of high-performing homes, CMS can improve effectiveness of its oversight and technical assistance for underperforming facilities, namely SFFs.

Reviewing Plans of Correction

AHCA Recommendation: CMS consider allowing surveyors to conduct desk reviews of Plans of Correction (POC) for all citations, in lieu of onsite surveys, including those initially cited at the Immediate Jeopardy (IJ) level, provided that:

a. The IJ has been verified as removed, with the facility's corrective actions implemented to mitigate the immediate threat, and
b. The remaining noncompliance is at a lower scope and severity level (i.e., not at the IJ level), and
c. The POC includes acceptable evidence of correction or systemic remediation as required.

The only exception to this proposal would be for situations where the IJ finding has not been removed. In those instances, an onsite revisit would still be required, consistent with current CMS policy in Chapter 7 of the SOM.

(via guidance update)

Rationale:

This proposal aligns with the temporary flexibility granted in QSO-20-35-All, which proved successful during the pandemic in ensuring compliance while streamlining the process. Specific benefits include:

- **Creating Government Efficiencies** Allowing desk reviews for corrected IJs improves the efficiency of the survey process. Reducing the burden on survey teams while still maintaining appropriate oversight allows for optimization of resources. Desk reviews decrease the administrative, logistical, and funding burden for state survey agencies and facilities, particularly when corrective actions have already been implemented and verified.
- **Proportionate Response**: Once IJ has been removed, the risk level has been substantially lowered. Desk reviews in such cases are proportionate and appropriate for promoting risk-based oversight.

State Survey Agency Revisits

AHCA Recommendation: Update guidance in Chapter 7 to direct State Survey Agencies (SSA) to schedule revisits no less than 10 days ahead of any Denial of Payment for New Admissions (DPNA), if the facility's alleged date of compliance is met (via guidance updates to the SOM, Chapter 7).

SSAs should schedule all revisits after the alleged date of compliance, but not later than the effective date of the DPNA if it is pending. AHCA recommends adding guidance to Chapter 7, under number 5 of the revisit guidelines to note that if a facility is approaching DPNA related to a previously cited deficiency; the revisit should be scheduled after the alleged date of compliance, but not less than 10 days before the effective date of the DPNA. Additionally, complaint investigations can create further scheduling conflicts, however, SSAs should make every effort to schedule revisits for previously cited deficiencies at least 10 days before the DPNA.

Rationale:

The current guidelines are clear about the scheduling of annual surveys by SSAs. However, the scheduling of revisit surveys is becoming increasingly problematic to ensure that revisits are

completed before the Denial of Payment for New Admissions (DPNA). This is causing providers across the country to face DPNA due to the guidance for revisits in Chapter 7 not being clearly defined. By clarifying the expected timeframe that SSAs are expected to complete revisit surveys, CMS will streamline the oversight and enforcement process in nursing homes.

Appeals System

AHCA Recommendation: Make changes to the nursing facility enforcement appeal system to address significant concerns with timeliness and the issue of burden of proof (via notice of proposed rulemaking).

A Handful of Small Changes That Could Produce Big Differences

1. **Timeliness**[1]
   (A) Amend 42 CFR 498.79 to require that, in SNF/NF appeals pursuant to 42 C.F.R. §488.330(e), Administrative Law Judges (ALJs) issue their written decision within 180-days from the closure of the record, i.e., hearing is complete, and all post-hearing briefing has been submitted. This revision would merely conform the timeframes for SNF/NF appeals with those adjudication deadlines that CMS has ***already*** apply to certain appeals under the Departmental Appeal Board system.[2] In the event of a failure to meet the deadline, any imposed Civil Monetary Penalty (CMP) will be automatically discounted by 50% and the proceeds reflecting the forfeited CMPs held in escrow returned to the nursing facility.
   (B) Amend 42 CFR 498.88 to require that if the Board fails to meet its 180-day deadline for issuing its decision of an appeal, then the nursing facility can advance the case directly to the judicial forum to which it would proceed in the normal course.[3]
2. **Burden of Proof** – that a new regulation be adopted requiring that Section 556(d) of the Administrative Procedure Act (APA) be the standard by which CMS would be required to meet for the burden of proof and that all subsequent "presumptions" articulated by the Departmental Appeals Board (DAB) are not to utilized by ALJs in these cases. [Note: In

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[1] The provisions of part 498 apply when SNFs and dually participating SNF/NFs request a hearing on a denial of participation, or certification of noncompliance leading to an enforcement remedy (including termination of the provider agreement), except State monitoring. *See 42 C.F.R. §488.330(e)(3)*

[2] The 180 day timeframes in 42 C.F.R. §498.79 were adopted by rule in 2008. *See 73 Fed. Reg. 36463 (June 27, 2008)* In the final rule, CMS stated, "*While we understand the desire to establish an efficient appeals process, we are adopting similar time frames as had been established for deciding a claims appeal before an ALJ or DAB (see § 405.1016(c))*."

[3] Similar provisions for "expedited access to judicial review" are already provided under 42 C.F.R. §405.990 for other types of provider appeals.

the alternative, the Hillman rule would be required to be reinstituted and applied in all nursing facility appeals.]

3. **Statements of Deficiencies** – that a new regulation be adopted providing that a Statement of Deficiencies ("SOD") does not constitute "evidence" for the purposes of meeting a party's burden of proof. Rather, competent evidence must be adduced to prove the violations alleged in the SOD.

Rationale:

History & Context of the Nursing Facility Enforcement Appeal System

The Social Security Act provides that where CMS makes an adverse finding associated with the Requirements of Participation for the Medicare/Medicaid programs, a nursing facility is entitled to an evidentiary hearing before a neutral administrative law judge to challenge the factual and legal bases for the sanction.[4]

In 1994, CMS adopted regulations at 42 C.F.R. Part 498 that provide for a trial-type adjudication before an Administrative Law Judge ("ALJ") of what is now called the "Departmental Appeals Board" ("DAB" or "Board"), to effectuate that right related to the imposition of specified enforcement remedies.[5] At any given time, there are about half a dozen ALJs who hear appeals in nursing facility cases (as well as appeals of many other DHHS actions).

Many courts have held that because Congress provided no express exemption from the Administrative Procedure Act ("APA"), the usual APA standards govern these Part 498 proceedings. The most basic "adjudication" rule under the APA is that the "proponent of an order," in this case, CMS, has the burden of proof to sustain the order throughout a proceeding contesting the order. (See 5 U.S.C § 556(d)[6]) Thus, in their earliest cases under Part 498, the

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[4] 42 U.S.C. § 1395i-3(h)(2)(B)(ii) (incorporating by reference 42 U.S.C. § 1320a-7a)

[5] The provisions of part 498 apply when SNFs and dually participating SNF/NFs request a hearing on a denial of participation, or certification of noncompliance leading to an enforcement remedy (including termination of the provider agreement), except State monitoring. *See 42 C.F.R. §488.330(e)(3)*

[6] Section 556(d) provides that:
"Except as otherwise provided by statute, the proponent of a rule or order has the burden of proof. Any oral or documentary evidence may be received, but the agency as a matter of policy shall provide for the exclusion of irrelevant, immaterial, or unduly repetitious evidence. A sanction may not be imposed or rule or order issued except on consideration of the whole record or those parts thereof cited by a party and supported by and in accordance with the reliable, probative, and substantial evidence. The agency may, to the extent consistent with the interests of justice and the policy of the underlying statutes administered by the agency, consider a violation of section 557(d) of this titles sufficient grounds for a decision adverse to a party who has knowingly committed such violation or knowingly caused such violation to occur. A party is entitled to present his case or defense by oral or documentary evidence, to submit rebuttal evidence, and to conduct such cross-examination as may be required for a full and true disclosure of the facts. In rule making or determining claims for money or benefits or applications for initial licenses an agency may, when a party will not be prejudiced thereby, adopt procedures for the submission of all or part of the evidence in written form."

Secretary's ALJs, and the courts, recognized that CMS had the burden under Part 498 to come forward with evidence to support any factual allegations (or, as CMS calls them, "findings") CMS identified as the "basis" for a sanction, and that if the agency failed to do so, then the petitioner prevailed "even if it offers no evidence at all."

If CMS established a "prima facie case" of noncompliance (which no regulation defines, but which the Board basically says means allegations, which, if true, could support a finding of noncompliance), the burden shifted to the petitioner to demonstrate compliance with the regulation in question, typically by showing that its staff's actions met applicable standards of care, or by an affirmative defense, typically that a resident had refused care, or that an adverse outcome was clinically unavoidable (for instance, the natural progression of a disease process). These principles became known as the "Hillman rule," after the case in which the Board first described them. (As discussed below, in recent years, the Board has receded from this rule in favor of various "presumptions" of noncompliance.)

The Board has no generally applicable procedural rules (other than for ministerial matters such as numbering of exhibits and the like), so the ALJs establish their own hearing procedures. For instance, some ALJs require submission of "written direct testimony" before the hearing, while others prefer to hear witnesses testify live. Hearings can take anywhere from a few hours to several days, again, depending on an individual ALJ's preferences. Hearsay is admissible, but different ALJs accord different weight to such evidence.

In recent years, budget restrictions were stated to require ALJs to conduct hearings by videoconference (in the past the ALJ would travel to a location near the appealing facility). The Board also has limited the number of hearings, causing a significant backlog, also because of purported budget issues. Thus, the number of ALJ and Board Decisions on the merits in nursing facility appeals has dropped dramatically from 50 or more per year (plus decisions on procedural issues such as timeliness) to only a handful today, about half of which ALJs now decide by "summary judgment" in favor of CMS (that is, without a hearing). Many cases languish without decision for many years despite the completion of the hearing and submission of all post-hearing briefing. Although the applicable regulation [42 CFR 498.74(a)] requires that such decisions be issued "as soon as practical after the close of the hearing," appeals regularly go without decision for as many as three to five years or more.

Following the hearing (or summary judgment motion), an ALJ must issue a written decision, and the losing party can request review by a three-member panel of the Board. The Board rarely entertains even oral argument, and almost always upholds CMS sanctions, almost always reversing every ALJ Decision in favor of a facility. Despite the regulatory requirement [42 CFR 498.88(g)] that the Board issue a decision "as appropriate, no later than 180 days after the appeal was received by the Board," this never occurs. Again, most decisions at this level do not get resolved for many years.

Judicial review of Board Decisions is bifurcated – appeals of civil money penalties go directly to the Court of Appeals; appeals of other sanctions to the District Court. The courts apply the traditional review standard of Section 706(2)(A) of the APA, that is, the agency action will be set aside if "arbitrary, capricious, or otherwise not in accordance with law"[7], which governs appeals of civil monetary penalties and also provides that the standard of review of the Board's findings of fact following an evidentiary hearing is "substantial evidence in the record, taken as a whole."

The Main Problems With The System

In recent years, the Board's administrative review process has rejected virtually every aspect of the APA and has taken on a life of its own. The Board largely has abandoned the Hillman rule described above, and now says that it is not bound by APA standards, even though Congress has provided no such exemption. The background for this rejection is murky, as the Secretary of Health and Human Services, or the Board, has never explained it in any official statement.

For instance, the Board has held in a series of cases over the past ten years that it now considers all of the allegations in a "Statement of Deficiencies" – including those a petitioner contests – to be "presumptively correct," and that a petitioner bears the burden throughout the proceeding somehow to "persuade" the Board otherwise.[8] This position is directly at odds with Section 556(d) of the APA.

The Board also has stated that it considers ALJ (and its own) review to be "de novo," and that it is not "restricted to the facts and evidence that were available to CMS when it made its decision," nor "how or why CMS decided to impose remedies," nor even the record developed in the Part 498 hearing. According to some of the Board's more recent cases, it says it views the Part 498 review process not to provide petitioners independent review of agency actions, but only to provide an opportunity for the Board to act as "the final step in the enforcement process," and even to "fix" flawed CMS or ALJ determinations. Thus, the Board now specifically holds that its review of ALJ Decisions is not comparable to the independent "oversight role of a federal court in reviewing agency decisions to determine if an adequate basis is articulated." Not incidentally, following its abandonment of the Hillman rule, the Board has reversed every ALJ Decision in favor of a nursing facility that CMS has appealed to it. No court has directly addressed most aspects of the Board's movement away from APA standards – at least not yet.

In fact, as discussed immediately below, the Secretary of Health and Human Services has long tried to limit review of CMS enforcement decisions, and the Board usually has accommodated

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[7] 65 42 U.S.C. § 1320a-7a

[8] See, e.g., Southgate Meadows Nursing and Rehabilitation Center v. CMS, DAB Dec. No. 2703 (2016); St. Joseph Villa v. CMS, DAB Dec. No. 2210 (2008) (reversing summary judgment for a petitioner where CMS relied only on the Statement of Deficiencies and offered no supporting evidence); Barbourville Nursing Home v. CMS, DAB Dec. No. 1962 (2005).

that effort, beginning with the threshold issue of what enforcement determinations are appealable at all. One recent development has accelerated that effort. Until recently CMS was authorized to collect CMPs only after the conclusion of an appeal, but in 2010, as part of the Affordable Care Act ("ACA"), Congress authorized CMS to adopt regulations that "may" provide for collection or "escrow" of CMPs pending appeals.

In 2012, CMS proposed a draft regulation, now codified at 42 C.F.R. § 488.431(b), to implement this ACA provision.[9] CMS explained its rationale for the regulation in a lengthy official comment in which it noted a series of reports by the Government Accountability Office and the DHHS Inspector General that had expressed concerns about "delays in payment of a civil money penalty" (in fact, the cited reports actually critiqued delays by CMS in processing survey documents and collecting CMPs after the completion of appeals), but CMS also recited that the agency's goal was "to eliminate a facility's ability to significantly defer the direct financial effect of an applicable civil monetary penalty until after an often long litigation process," which CMS specifically derided as a distraction from its enforcement prerogatives.

That stated rationale is critical, for the Supreme Court has held that the government may seize money or property prior to a hearing in non-criminal cases only in "extraordinary situations where some valid governmental interest is at stake that justifies postponing the hearing until after the event." Nevertheless, CMS dismissed commenters' concerns about the due process implications of seizing civil money penalties without prior administrative or judicial review, stating in its Official Comment that it would create a new "independent informal dispute resolution process" ("IIDR"), in which sanctioned parties could dispute deficiencies prior to, or as an alternative to the appeal process.

Congress thus provided IIDR as a due process counterweight to escrow – the provisions are in the same statutory section – but CMS routinely disregards or rejects IIDR recommendations in favor of facilities. Even worse, numerous facilities have been required to deposit into escrow amounts that range between $500,000 and $1 million (or even more), only to have to wait for a decision that may not be issued for many years. And when that decision is made, CMS nearly always prevails because the Board has made the burden of proof so miniscule for CMS and so devoid of evidentiary support. For all these reasons, the system is completely broken and in need of reform.

The agency's efforts to limit challenges to its enforcement decisions also have been baked into its regulations and its culture. The administrative and judicial review provisions of the Social Security Act appear, on their face, to allow challenges to any enforcement determination or decision by the Secretary of Health and Human Services. However, the system is rendered entirely devoid of due process because CMS' appeal regulations, and the Board's interpretation

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[9] 76 Fed. Reg. 15106 (March 18, 2013).

and application of those regulations, erect significant substantive limits on administrative appeals. Those limitations, when coupled with the significant backlog of ALJ decisions and Board appeals and lack of timely decisions frustrate the intent of the regulations to give providers a meaningful appeal process. CMS can easily fix those legal impediments as explained in our recommendations outlined above.

Special Focus Facility Program

AHCA Recommendation: Revise the Special Focus Facility (SFF) Program to support sustainable quality improvement (via Guidance Update to the SFF Program). This includes:

1) Targeted technical assistance that addresses root causes and is non-punitive.
2) Allow Civil Monetary Penalties (CMPs) to be retained for quality improvement uses.
3) Revised graduation criteria to improve consistency.

Rationale:

The SFF program is supposed to identify facilities in need of improvement and assistance; however, the federal government provides little assistance to help these facilities get better. Simply increasing inspections and public shaming facilities that are struggling is not going to help them change or improve. We recommend creating programs that can help identify and address the reasons for poor performance, ensure providers have the resources to make improvements, and eventually graduate from the program. Turning around these facilities should be the goal for the sake of residents, families, and staff.

These revisions are aimed at enhancing effectiveness in fostering systematic and sustainable improvements in nursing home quality. The aim is to support poor-performing nursing homes by reallocating existing resources and implementing structural changes to drive sustainable improvements in care quality and resident outcomes.

- **Focus on Resident-Centered Care**: Adjusting the criteria to emphasize compliance with resident care standards aligns the program with its core mission of improving care quality for nursing home residents. We recommend that F851 be added to the exclusion list for graduation requirements, in alignment with non-resident care-centered tags such as F812.
- **Strengthened Workforce Stability**: Providing targeted assistance and allowing facilities to reinvest penalties into quality improvement efforts will help stabilize struggling facilities, reduce staff burnout, and improve job satisfaction—key factors in retaining and attracting skilled caregivers.
- **Enhanced Support for Improvement**: Providing technical assistance through Quality Improvement Organizations (QIOs) or other approved parties will address the root causes of deficiencies and promote meaningful, sustainable change. Redirecting resources to

promote efficiency by reallocating the resources used to support the annual survey frequency activities to focus on targeted interventions for SFF-designated facilities, ensuring focused support for facilities in most need without increasing overall expenditure.

- **Encouraged Sustainable Improvement**: Offering technical assistance through assessments or performance audits, improvement plans, consultation, training, quality monitoring tools, feedback loops, and progress reviews provides holistic support that equips facilities to maintain high standards of care after SFF designation. Provide a rationale and trends as to why a facility is selected for the SFF candidate list.
- **Alignment with Program Goals**: Revising graduation requirements to mirror those used in the Hospice Special Focus Program ensures consistency and a clear pathway to success, focusing on meaningful compliance without penalizing unrelated deficiencies. This is the recommended criteria: No Immediate Jeopardies (IJ) on two consecutive surveys; all citations have been returned to substantial compliance; and there are no pending complaint investigations that trigger an IJ.
- **Targeted Use of CMPs**: Allowing facilities to retain CMPs for quality improvement initiatives equips them with the necessary resources to address systemic issues and prevent the recurrence of deficiencies.
- **Streamlined Program Management**: Clearer guidelines and consistent communication with state survey agencies (SSAs) and stakeholders will enhance program transparency and implementation.

Telehealth

AHCA Recommendation: Expand flexibility for telehealth visits and allow non-physician practitioners (NPPs) for both initial visits and routine visits. (via guidance update)

§483.30(c) and F712 discuss the frequency of physician visits. The regulation discusses the timeliness of the visits, for example, a physician must see a resident at least once every 30 days for the first 90 days. Interpretive guidance should be updated to include allowances regarding telehealth opportunities during these required visits.

In addition, telemedicine provided by clinical staff should be recognized in the Payroll Based Journal. This could include opportunities for remote nurses to provide education to residents prior to discharge.

Rationale:

Considering workforce shortages, including among physicians, especially in rural areas, expanding these flexibilities would improve access to care to allow physician visits to be

conducted by telehealth with the assistance of an on-site nurse. CMS also states in F712 guidance that a physician has generally had contact with the residents immediately preceding an admission; therefore, if a state has expanded the scope of practice for non-physician practitioners (NPP), CMS should defer to the states on issues of scope of practice and determinations as to resident health and safety. That is, defer to states in which practitioners can perform initial comprehensive assessments and other medical duties and visits.

Accountability of Regulatory Bodies

AHCA Recommendation: Require accountability and effectiveness in CMS policy development, implementation, and monitoring (suggested via rulemaking, NPRM).

CMS should adopt a structured approach to regulatory, guidance and policy changes that require evidence to support the changes, expected outcomes of the changes, metrics, and timelines for re-evaluation to determine if the changes provided intended benefit or should be modified/discontinued.

Rationale:

- **Outcome Based**: Requiring CMS to provide evidence and clear expected outcomes builds trust with residents, nursing home providers, and policymakers. It allows stakeholders to understand the basis for the changes, reducing perceptions of arbitrary decision-making.
- **Data-Driven Decisions**: Evidence-backed policies are more likely to anticipate and mitigate potential negative effects on the healthcare system and align with the broader healthcare trend toward data-driven, evidence-based practices, ensuring CMS policies reflect modern standards. Additionally, establishing metrics would ensure there is a mechanism to measure true impact versus simply adding additional burden. CMS can track whether policies achieve results and allow for adjustments if needed.
- **Alignment on Results**: Clearly identifying expected results provides a concrete definition of what success looks like for any policy change and helps healthcare providers and other entities align their efforts with CMS's goals, improving implementation efficiency.
- **Targeting Resources**: Requiring CMS to focus on changes that provide real value and save costs will support resource utilization by targeting policies toward demonstrable needs with expected outcomes.
- **Consistent Assessments**: A standardized approach to policy evaluation minimizes disruption by setting clear timelines for review and adjustment.
- **Making Improvements**: These requirements will allow CMS to learn from outcomes and foster innovation. If metrics show a policy is not achieving desired results, CMS can test alternative approaches in a structured and systematic manner. A focus on evaluation fosters a

culture of learning and continuous improvement within CMS and the broader healthcare ecosystem.

- **Enhancing Government Accountability**: Evidence-based, measurable policies help ensure CMS changes are genuinely improving care for beneficiaries and not just adding additional burden to providers. Transparent decision-making reduces the likelihood of bias or inequitable impacts on different populations or sectors.

STREAMLINE REGULATORY REQUIREMENTS

Surveyor Guidance

AHCA Recommendation: Withdraw the Appendix PP guidance changes, which became effective April 28, 2025, per:

- QSO-25-07-NH issued November 18, 2024,
- QSO-25-12-NH issued January 15, 2025, and
- QSO-25-14-NH issued March 10, 2025.

AHCA recommends withdrawing the recent changes and returning to the previous version of Appendix PP dated August 8, 2024, with any relevant updates made consistent with regulation or guidance changes made by the current Administration (via Guidance Update). AHCA further recommends removing clinical judgement from surveyor guidance and returning to surveying for regulatory compliance (via Guidance updates to Appendix PP).

Rationale:

The guidance changes announced in November 2024 and January 2025 included significant updates to surveyor guidance across several regulatory areas. However, these changes are beyond the scope of the actual regulations and shifted the focus from patients to paperwork. They are further slowing the survey process, diverting both provider and surveyor resources, and reducing the effectiveness of the oversight system.

Specifically, the surveyor guidance changes created unreasonable expectations of medical prescribers and nursing homes that can cause detrimental consequences for residents. The revised guidance also introduced additional documentation and compliance obligations, further escalating the administrative workload and burden for LTC providers and surveyors.

Examples of increased regulatory burden include:

- Added expectation by CMS for facilities to obtain (from hospitals) or document comprehensive records for every mental health diagnosis (e.g., schizophrenia) made by a licensed physician, regardless of whether this is a new or existing diagnosis.

    - This requirement increases administrative workloads and can cause delays in necessary treatment. Physicians currently have regulations and guidelines that govern their diagnosing and prescribing practices, making this regulation duplicative. Further, this additional paperwork requirement is an example of overreach by requiring physicians to further justify their prescribing decisions for patients in a nursing home that they do not have to further justify for similar patients in the community. CMS places this expectation on the nursing home which requires the facility to question the clinical judgment of practitioners, which is problematic for all involved and not necessarily in the best interest of the residents.

- Implementing the new guidance required substantial operational adjustments, including staff training, policy revisions, and system updates.
    - These requirements diverted critical resources from direct resident care. These additional administrative burdens may discourage nurses and other staff from remaining in or joining the nursing home sector, further exacerbating workforce shortages.

Returning to Surveying for Regulatory Compliance

Additionally, sub-regulatory guidance is being written more frequently in a manner that requires surveyors to question a medical provider's clinical judgement, as opposed to surveying to the regulation. Examples of this guidance include the following areas:

- Significant Medication Error
- Gradual Dose Reductions (GDR) and antibiotic stewardship
- Pharmacy recommendations
- Wound care treatment and diagnosis
- Rehospitalization
- Diagnoses, for example, Huntington's Disease
- Assisted with falls without injury, questioning why the facility did not send the resident out after a fall

Medical providers, including physicians and physician extenders, undergo extensive training regarding clinical decision making as it relates to patients' individualized care needs. Surveyors have begun, as written in sub regulatory guidance, questioning the medical decisions made by physicians in nursing homes. This is noted throughout Interpretive Guidance in Appendix PP. Surveyors are tasked with surveying the regulation, which should not extend to questioning a doctor's medical judgement about diagnoses, and/or medication prescribing.

Furthermore, the new guidance includes accusatory language that suggests nursing home staff provide additional medications for convenience and was revised to include instances when medications are "used to cause symptoms consistent with sedation and/or require less effort by facility staff". This language is subjective, calls into question the prescribing efforts of physicians, and puts at risk unfairly penalizing facilities/practitioners who are providing appropriate resident treatment.

Included in the Executive Order, *Ensuring Lawful Governance and Implementing the President's "Department of Government Efficiency" Regulatory Initiative,* the White House provided a list of reasons Federal agencies should not overregulate. One reason included is, regulations should not be added that impose significant costs upon private parties that are not outweighed by public benefits. The changes noted above that were made to Appendix PP State Operations Manual Surveyor Guidance represent unnecessary burdensome cost to providers that are not outweighed by public benefits and therefore, should be withdrawn consistent with this Executive Order.

Discharge Notice Guidance

AHCA Recommendation: Streamline and improve the 30-day transfer/discharge notice guidance as written in Appendix PP (via guidance change to Appendix PP).

Update the discharge notice guidance to only require a 30-day discharge notice for residents residing in the facility for greater than 30 days and specify that this notice is not intended for the transfer of an individual in need of emergent care.

Rationale:

Currently, facilities are tasked with executing the same policies and procedures for both discharges and transfers, whether planned, unplanned, or even when emergent. Requiring a health care facility to provide a formal advance written notice of transfer to the resident and the resident's representative, as well as the Ombudsman, when the resident needs an acute/emergency care visit to a hospital, is unnecessary and duplicative due to the emergent nature of their transfer, and shifts the focus from the more important needs of the resident.

CMS has stated verbally that they expect a 30-day notice for all resident discharges. However, this process and current forms utilized by states do not accommodate such a request. Issuing a 30-day discharge notice to a person who is staying in the SNF for less than a 30-day stay, such as for short-term rehab only creates confusion for the patient and unnecessary volume of paperwork processing for others. A list of short-stay residents discharging from the facility in less than 30 days can be sent to the Ombudsman monthly.

The 30-day notice should only be given to residents who are not on a skilled stay (Medicare Advantage or Medicare Part A). These residents are given a Notice of Medicare Non-Coverage (NOMNC) to notify of their discharge, as well as given appeal rights through the NOMNC.

Five-Star Rating System

AHCA Recommendation: Update the CMS Five-Star Rating System per the following recommendations (via Guidance Update to Five Star Technical User Guide).

Survey:

- Move to a two-survey cycle, instead of three.
- Shift to 20% at each star rating distribution for the survey (currently, only 10% are 5-star).
- Remove surveys older than three years from the Abuse Icon criteria.
- Allow lower scoring of past non-compliance deficiencies below Immediate Jeopardy (IJ).

Quality:

- Have the Quality rating drive the Overall rating calculation. Currently, the Survey rating component drives the overall rating calculation, yet survey backlogs are chronic, and facility survey performance is being rated for surveys that occurred seven or eight years ago or more, which most often is not relevant to current facility performance. Rather, quality measures are calculated on current/recent information from routine resident assessments/claims and provide a timelier picture of facility performance than the current survey rating.
- Stop downgrading the overall Quality and long-stay Quality ratings to one star for six months as a schizophrenia audit penalty. Long-stay antipsychotic measure suppression could still be applied by CMS for six months.

Staffing:

- Resume 4-Stars in Staffing add an Overall star.
- Stop forced rating downgrades to 1-Star as a Payroll-Based Journal (PBJ) audit penalty.
- If CMS keeps the approach of forced rating downgrades, this should only be applied after the facility is given the ability to correct the data discrepancy and fails to do so within a reasonable time period.
- Per PBJ policy recommendations, allow facilities at least 14 business days to review and correct the PBJ data post the reporting deadline.

Rationale:

The Five-Star Rating System is a key resource for residents and families in selecting a nursing home. The public facing data should reflect actual performance and be consistent across facilities, to assist consumers in making the most informed decision about their care.

A more transparent and fair rating system can positively impact staff morale and public perception of the nursing home workforce, making it easier to recruit and retain high-quality employees.

Under the prior Administration and despite the absence of legal authority to do so, CMS increasingly used the Five-Star Rating System as an enforcement mechanism on nursing facilities (e.g., forced rating downgrades). These downgrades often penalize facilities by reducing their Medicaid payments (which are already underfunded) due to reimbursement methodologies employed by States that have been approved by CMS as part of the State Plan process. In some states, facilities have lost significant resources (some in excess of $1 million) by virtue of these downgrades.

These downgrades have also impacted facilities and their relationships with consumers, hospitals, and health plans/insurers. Not only have these downgrades produced inaccurate and incomplete information about facilities that were widely disseminated; but it also threatens to shut down facilities. For example, facilities have lost the ability to participate in health plan/insurer networks by virtue of these downgrades. The loss of network status not only precludes certain Medicare beneficiaries from accessing the care services these skilled nursing facilities offer, but also can result in significant losses of revenue, which for some facilities may be existential in nature.

Streamlining the rating system to align with AHCA's recommendations will make the ratings more transparent, balanced, and accurate, providing families with the best possible information when making critical decisions about their loved ones' care.

Strict Liability

AHCA Recommendation: To provide consistent application of enforcement across healthcare settings, we recommend discontinuing the use of strict liability and citing facilities for identified non-compliance with a regulation. This may be accomplished by making modifications to guidance in Appendix PP, specifically to F600 and F689.

Rationale:

Current strict liability policies penalize nursing homes even when the nursing home has taken appropriate actions and could not have reasonably prevented an incident from occurring. Similar incidents in other healthcare settings do not take the same enforcement approach, raising concerns regarding regulatory inconsistencies within CMS.

Revising the guidance for F600 determinations to a non-compliance-based approach will create a more reasonable regulatory framework, ensuring nursing homes are held accountable in a fair manner and reducing undue penalties for circumstances beyond their control.

Similarly, while F689 does not currently address strict liability, surveyors frequently cite facilities for accidents that were outside of their control and unpreventable. The current strict liability approach discourages skilled caregivers from working in nursing homes, fearing unfair penalties for events beyond their control. By fostering a more balanced regulatory approach, this change can help retain experienced staff and attract new professionals to the sector.

Recommended addition to Appendix PP guidance for F689:

> When assessing compliance under F689, surveyors should assess whether the facility has a system in place for identifying hazards, evaluating and eliminating hazards and risks, implementing interventions, and monitoring the effectiveness of the interventions. Unavoidable accidents are defined in the interpretive guidance as an accident that occurred despite sufficient and comprehensive systems designed and implemented to identify, evaluate, and eliminate risks, including implementing interventions and monitoring of their effectiveness. If each of these items were present, the facility is determined to be in substantial compliance and should not be cited with noncompliance at F689.

Recommended Changes to Appendix PP -Determination of Findings and Potential to Foresee Abuse

> When assessing compliance under F600, surveyors should assess whether the facility has a system in place for abuse protection including Screening; Training; Prevention; Identification; Investigation; Protection; and Reporting/Response. If a facility has a system in place and has taken appropriate steps for abuse protection, the facility is determined to be in substantial compliance and will not be cited with noncompliance at F600.

Cross-Referencing of F-Tags

AHCA Recommendation: Provide direct guidance on how cross-referencing of F-tags should be used for all scope and severity levels (via guidance update in Chapter 7 of the SOM).

We recommend CMS include the following direction in the Citations and Description Section, specifically the Citations section (7006.1):

> **Cross-References of Any Citation**

> The cross-referencing of requirements is an acceptable form of documentation on Form CMS-2567 only when it is applicable and provides additional strength to the linked citations. Cross-referencing is most effective when the linked citations have a direct cause-and-effect relationship to the deficient practices described in both citations. In all instances, the linked citation must contain sufficient evidence to demonstrate noncompliance with the referenced regulation at the linked site.
>
> Furthermore, noncompliance with one regulation or survey tag does not automatically trigger noncompliance with a related regulation or tag. Surveyors must analyze the facts of the noncompliance against the relevant regulations or tag. If the survey team finds that the same incident or facility practice results in multiple violations, the team must be able to articulate how the incident or practice represents a distinct violation of each regulation or tag. Although a comprehensive statement may contain facts illustrating deficiencies at multiple tags, surveyors may not simply copy and paste from one tag to another. Even if multiple deficiencies share common facts, surveyors may need to conduct additional investigation to evaluate additional tags thoroughly and to be able to document them so that each tag stands on its own.

Rationale:

This recommendation is intended to make the guidance for cross-referencing F-tags clearer for both surveyors and providers, so that both parties understand how and when the process should be used. Inconsistencies in the application of cross-referencing tags have been widely observed, resulting in an overall increase in the number of F-tags and the number of times an F-tag is cross-referenced, especially for Immediate Jeopardy citations.

It is understood but not explicitly stated in guidance that cutting and pasting deficient practice documentation should be prohibited when cross referencing. Facts should be included about what the provider did that was not in substantial compliance with the cross-referenced tag. Cross-referenced citations should not automatically be cited at the same scope and severity. Each citation should be determined based on the severity of the deficient practice being cited.

Immediate Jeopardy Definitions & Assessment

AHCA Recommendation: Implement key revisions to the Immediate Jeopardy (IJ) definitions and associated assessment criteria in the SOM-Appendix Q to ensure uniform application, mitigate subjectivity, and enhance regulatory clarity (via guidance updates to Appendix Q).

Specifically:

a. **Add the word “serious” before harm and impairment throughout when referring to the definition of Immediate Jeopardy** as outlined in the existing *Key Components of Immediate Jeopardy* section of Appendix Q.
b. **Replace "reasonable expectation" with "high probability".**
c. **Add statement to clearly define Immediate Jeopardy**: Immediate Jeopardy only be cited in those situations where there is a need for immediate corrective action to prevent the serious injury, serious harm, serious impairment, or death from occurring or recurring. For the jeopardy to be immediate, it must be present and actual when cited, identified onsite in the facility, and thus, surveyors are not able to cite an incident as a retroactive Immediate Jeopardy or after leaving the facility.

    b. **Modify language for scope determination to clarify that scope is a <u>pattern</u>** when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice <u>at the same or greater severity</u> The effect of the deficient practice is not found to be pervasive throughout the facility.

    Scope is <u>widespread</u> when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility’s residents. Widespread scope refers to the entire facility population, not a subset of residents or one unit of a facility. In addition, widespread scope may be identified if a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would be likely to affect many residents <u>at the same or greater severity</u> and is, therefore, pervasive in the facility.

Rationale:

Ensure Consistent Application of Immediate Jeopardy: We recommend introducing uniform language, such as consistently using "serious harm" instead of "harm," to reduce ambiguity and assure a standard interpretation of Immediate Jeopardy scenarios across facilities nationwide.

Survey data demonstrates that in some regions, IJs are being cited at an unusual rate. While some of this may be due to an increase in complaint and facility-reported incident (FRI) surveys, there are instances where IJs are being cited for any level of harm or potential for harm.

Reduce Subjectivity: Replacing "reasonable expectation" with "high probability" aligns definitions with commonly accepted interpretations, minimizing subjective variability in enforcement decisions. The SOM outlines how an “*Immediate Jeopardy* situation is one that is clearly identifiable due to the <u>severity of its harm</u> or <u>likelihood for serious harm</u> and the immediate need for it to be corrected to avoid further or future <u>serious harm.</u>” *Likely* is defined

by Merriam-Webster as having a high probability of occurring or being true. Using this clearer language can help bring consistency to the oversight process.

Clarify Citation Standards: Limiting IJ citations to situations requiring immediate corrective action clarifies that surveyors should cite Immediate Jeopardy only when the urgency of correction is present, that they must remain onsite in the facility, and avoids retrospective misapplications. AHCA recommends that Immediate Jeopardy only be cited in those situations where there is a need for immediate corrective action to prevent the serious injury, serious harm, serious impairment, or death from occurring or recurring.

For example, if the SNF has corrected the alleged noncompliance, the immediacy has been removed and there is no longer a high probability (or even a reasonable expectation under the current definition) of recurrence, and an Immediate Jeopardy should not be cited. (Note: CMS already partially recognizes this as there is a reduction in points and CMPs for corrected past noncompliance IJ citations). For jeopardy to be immediate, it must be present and actual when cited, identified onsite in the facility, and thus surveyors are not able to cite an incident as a retroactive Immediate Jeopardy or after leaving the facility

Align Definitions with Seriousness of IJ: Updating the Scope and Severity grid to reflect the seriousness of IJ situations ensures consistency with the definitions outlined in SOM-Appendix Q, aiding surveyors in distinguishing IJ from other levels of harm or noncompliance.

Foster Regulatory Precision: The proposed revisions offer clearer guidelines to surveyors, enhancing transparency, reducing disputes, and improving compliance adherence by facilities.

Support Frontline Caregivers: Reducing ambiguity and subjectivity in IJ citations will help create a clearer survey environment for caregivers, ensuring they are not penalized for circumstances beyond their control. This can lead to improved job satisfaction and reduced turnover, helping to stabilize the nursing home workforce.

In addition to the above:

AHCA Recommendation: Through new State Performance System Standards (SPSS) measures, CMS should assess the timeframe in which an Immediate Jeopardy (IJ) is identified and the subsequent notification to facility leadership as well as the provision of the IJ template. Also, as part of this assessment, CMS should determine whether surveyors are present in the facility to issue the IJ template and monitor compliance with this measure through the SPSS program.

Rationale:

Upon identification that an IJ exists and there is agreement from the SA (and/or RO), current guidance directs that the survey team must immediately notify the administrator and an IJ

template be provided to facility leadership. Additionally, guidance from Appendix Q directs that surveyors must return to the facility to validate the finding onsite using the IJ template.

Nursing home providers frequently report examples of inconsistencies in this process, including IJ templates being issued by phone after surveyors have already left the facility, and a lack of timeliness in reporting the immediate jeopardy to nursing home leadership. Further, facilities having difficulty obtaining feedback and acceptance of plans provided to surveyors in response to receiving the IJ. Providers report instances of multiple attempts to call and/or fax to the State Survey Agency with delayed response, and examples of IJ templates being issued as many as 15 days after a deficient practice noted.

These process inconsistencies and delays in communication of incidents considered to be classified as Immediate Jeopardy by surveyors not only create administrative burdens, but most importantly, could cause harm to residents if a true immediate jeopardy situation exists. It stands to reason that State Survey Agencies and CMS would assure that the IJ process follows the expected urgency outlined in the guidance, and in executing a plan that would quickly safeguard residents.

Food & Nutrition Services

AHCA Recommendation: Modify §483.60 Food and Nutrition Services to increase the availability of Directors of Food and Nutrition Services by reinstating the experience provision that expired October 1, 2023 (via Interim Final Rule).

Rationale:

Federal regulation 483.60 contains requirements related to the food and nutrition services provided in the nursing home setting. As part of these requirements under subsection (a) Staffing, the agency sets forth requirements for the facility to "employ sufficient staff with the appropriate competencies and skills to carry out the function of the food and nutrition service". The regulation further mandates that the food service director meets the minimum qualifications outlined in the rule. One of the options to meet these requirements includes having two or more years of experience in the position of director of food and nutrition services in a nursing facility setting and completing a course of study in food safety and management, however this option expired on October 1, 2023.

We recommend CMS issue an Interim Final Rule to modify 483.60 Food and Nutrition services as follows:

> "Has 2 or more years of experience <u>working</u> in ~~the position of director of~~ food and nutrition services in a nursing facility setting <u>or other healthcare setting</u> and has completed a course of study in food safety and management~~, by no later than October 1,~~

~~2023,~~ that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving".

AHCA/NCAL supports ensuring that nursing home staff who work in food, nutrition, and dietary services have the necessary experience and training. However, the current requirements limit the availability of recruiting directors of food and nutrition who have valuable experience working in the field. Reinstating the option for experience as well as course completion will help attract qualified individuals possessing the practical knowledge necessary for success to this critical position. It will also allow for expanding career pathways for nursing home staff and the pool of potential candidates.

Long-term care facilities are experiencing a critical shortage of qualified personnel in food and nutrition services. By recognizing relevant work experience as a qualification, this revision would broaden the pool of eligible candidates, mitigating staffing shortages and ensuring continuity of high-quality care for residents.

It would also promote career advancement within the nursing facility setting and help retain staff who are already familiar with the unique needs of the elderly population. Recognition of on-the-job experience would allow facilities to promote internal candidates who are already familiar with residents' dietary preferences, cultural needs, and facility protocols. Familiar leadership fosters trust and continuity of care, which is particularly important in long term care settings where resident satisfaction and well-being are tied to personalized, consistent services.

The proposed revision would bring nursing facilities' food service qualifications in line with the sector’s best practices, ensuring that skilled and experienced individuals are not excluded from leadership roles based on outdated or overly restrictive criteria.

Enhanced Barrier Precautions

AHCA Recommendation: Modify CMS and CDC guidance to allow each facility to develop a plan for Enhanced Barrier Precautions that is informed by standards of practice while balancing the need for a homelike environment in nursing homes (via Guidance Update by CMS and CDC).

Rationale:

Enhanced Barrier Precautions (EBP) are infection-control practices to prevent the spread of multi-drug-resistant organisms (MDROs) in nursing homes. EBP recommends gown and glove use for certain residents during specific high-contact resident care activities associated with MDRO transmission, such as dressing, bathing/showering, transferring, and changing linens. EBP was introduced by the CDC in 2019. Although residents with MDROs can be found in

many different types of healthcare facilities, at this time the CDC recommends the use of EBP only for nursing homes.

Surveyors began citing facilities for failing to use EBP in the fall of 2023. However, CMS did not include EBP in guidance until spring of 2024. Historically, these guidance decisions also went through the Health Infection Control Practices Advisory Committee (HICPAC). With the recent dissolving of HICPAC, nursing homes continue to follow current CDC guidance, and CMS surveys to this guidance as well.

Currently, nursing home residents across the country report feeling embarrassed and uncomfortable due to the overly restrictive nature of EBP. Residents and staff report that the EBP requirements are burdensome and make the residents feel as if others believe they are sick or infectious. While CMS has consistently emphasized the importance of resident quality of life and homelike environments in the nursing home setting, the current guidance is in conflict with that approach. Cross-agency collaboration between the CDC and CMS to arrive at guidance that balances safety and achieves CMS's call for a more homelike environment would greatly enhance resident quality of life.

COVID-19 Guidance

AHCA Recommendation: Update COVID-19 guidance related to return-to-work requirements for nursing home staff, as well as COVID-19 isolation requirements for residents (via Guidance Update by CMS and CDC).

Rationale:

Similar to Enhanced Barrier Precautions, the COVID-19 era return-to-work and isolation requirements are based on CDC guidance that has not been substantially updated since 2023.

Since the public health emergency (PHE) for COVID-19 ended in the spring of 2023, the prevalence and severity of COVID-19 in nursing homes (and across the country) has greatly diminished. While nursing homes remain committed to preventing, monitoring, and treating COVID-19, these restrictive requirements are largely outdated given where we are today and are unnecessarily extending restrictions on staff and residents. In fact, the Healthcare Infection Control Advisory Committee (HICPAC) had reviewed and voted upon updated guidance during their November 2024 meeting.

- **Return-To-Work**:

  Current guidance: In healthcare settings, the return to work criteria is at least 7 days have passed since symptoms first appeared if a negative viral test is obtained within 47 hours before return to work (or 10 days if testing is not performed or if a positive test at day 5-7),

and at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) have improved. However, the general population may return to work five days after a positive test.

We recommend updating this guidance, which is consistent with HICPAC's voted upon guidance to states:

- **Restrict from work until at least 3 days have passed from symptom onset or from their first positive test if asymptomatic; AND**
- **They are fever-free for at least 24 hours without the use of fever-reducing medications; AND**
- **Symptoms are improving; AND**
- **They feel well enough to return to work.**

- **Isolation Requirements**:

  Current guidance: In nursing homes, residents must be isolated in a single-person room with the door kept closed, if they have suspected or confirmed COVID-19 between 7 and 10 days, depending on whether they were tested. This isolation greatly exceeds the public's isolation requirements.

  We recommend updating to be consistent with the above recommendation:

  - **Isolate until at least 3 days have passed from symptom onset for suspected COVID-19 or from their first positive test if asymptomatic; AND**
  - **They are fever-free for at least 24 hours without the use of fever-reducing medications; AND**
  - **Symptoms are improving.**

Updating this guidance based on the HICPAC recommendations will support workforce efforts and ensure residents are not facing unnecessary restrictions in their day to day life in a nursing home.

In-House Training Programs for Certified Nursing Assistants

AHCA Recommendation: Support legislation that would allow SNFs to resume or initiate in-house nurse aide training programs if deficiencies leading to civil monetary penalties (CMPs) are corrected and meet other patient safety criteria (via statute change).

The bipartisan and bicameral bill, S. 1749/H.R. 8244, or the Ensuring Seniors' Access to Quality Care Act included such statutory modification.

Rationale:

Current federal laws impose a two-year ban on nurse aide training programs in SNFs if civil monetary penalties (CMPs) exceeding $12,924 are issued, even for reasons unrelated to quality of care or systemic issues. These restrictions prevent thousands of facilities from starting or resuming in-house nurse aide training programs.

Helps Address Caregiver Shortages: Certified Nursing Assistants (CNAs) are the backbone of providing care in SNFs. With a nationwide CNA shortage, expanding training opportunities is critical to ensuring seniors have access to high-quality care. Allowing SNFs to resume in-house training programs will strengthen workforce pipelines, particularly in rural and underserved areas, by making CNA training more accessible and helping to address workforce shortages.

Holds Nursing Homes Accountable: S. 1749/H.R. 8244 allows facilities to resume their training programs only if:

- The cited deficiencies have been corrected.
- The cited deficiencies did not result in immediate patient safety risks or harm from abuse or neglect.
- There have been no repeat deficiencies related to direct patient harm in the past two years.

Encourages Workforce Development: SNF-based nurse aide training programs not only offer on-the-job experience, but create job opportunities and career mobility. Many CNAs trained in these programs advance to become licensed practical nurses (LPNs), registered nurses (RNs), or SNF administrators.

Life Safety Code

AHCA Recommendation: Adopt the 2024 edition of the National Fire Protection Association (NFPA) 101 for the Life Safety Code® (LSC) (via Guidance Update).

Rationale:

This version of the LSC addresses emerging trends and challenges in building design and safety and will streamline the process for both CMS and providers. In addition, it places increased emphasis on occupant empowerment and early fire response, enhancing safety for residents of nursing homes.

The updated construction requirements for existing nursing homes found in the 2024 edition of the Life Safety Code® could improve the number of facilities in compliance with K161, the tag for construction-related deficiencies. Many facilities would no longer require an annual Fire Safety Evaluation System (FSES) waiver to demonstrate Life Safety Code® equivalency. It

would inherently reduce the time required for State Survey Agencies and CMS Locations to review construction-related FSES waiver submissions.

Additionally, it would align life safety requirements for both CMS and the U.S. Department of Veterans Affairs. Some facilities are currently surveyed by two different editions of both codes.

The use of the 2024 edition would mitigate conflicting testing, inspection, and maintenance requirements that are created when multiple editions of various codes and standards are applied. State and local Authorities Having Jurisdiction (AHJ) commonly adopt and enforce their state building code.

OPPORTUNITIES TO REDUCE ADMINISTRATIVE BURDEN OF REPORTING AND DOCUMENTATION

Respiratory Illness Reporting

AHCA Recommendation: Discontinue mandatory National Health Safety Network (NHSN) reporting and allow for voluntary reporting (via Interim Final Rule).

Rationale:

In November of 2024, as part of the Calendar Year 2025 Home Health Prospective Payment System Rate Update, CMS released new acute respiratory illness reporting requirements for nursing homes, which replaced the requirements at 483.80 (g). These requirements added even further data elements required by providers to report to NHSN to include the following:

- Facility census;
- Resident vaccination status for COVID-19, Influenza and RSV;
- Confirmed resident cases of COVID-19, Influenza, and RSV (overall and by vaccination status); and
- Hospitalized residents with confirmed cases of COVID-19, Influenzas and RSV.

The continued mandatory weekly reporting of acute respiratory illness on the NHSN platform by nursing home providers is unnecessary, duplicative, and burdensome. The COVID-19 Public Health Emergency (PHE) ended in May 2023, and weekly reporting is no longer necessary.

- **Duplicative Reporting**: Relevant COVID-19 reporting has been incorporated into other systems and programs. Resident- level vaccination status includes COVID-19 and influenza and is reported via Minimum Data Set (MDS), the standardized assessment tool for nursing homes. Respiratory illnesses are reported to many local public health

departments, which results in duplication of data, causing additional unnecessary reporting burdens for facilities.

- **Inconsistent and Ineffective**: The misalignment between NHSN reporting definitions and ICD-10 coding standards creates ongoing inconsistencies and inefficiencies in data reporting. The NHSN system is flawed with errors, which results in additional unnecessary time spent completing administrative tasks and taking time away from resident care. Delays in getting NHSN logins persist, and the email-only Help Desk causes further delays due to back-and-forth messages that could be resolved faster with a phone Help Desk or online chat system.
- **Putting Patients Over Paperwork**: Elimination of this requirement will allow health care professionals more time to focus on delivering quality care to residents in long term care facilities. Related to administrative burden, facilities report they spend anywhere from 2-8 hours per week on NHSN reporting. Additional administrative time is required to gain login clearance to the system and work with the multi-factor login requirements.

Facility Assessment

AHCA Recommendation: Remove the §483.71 Facility Assessment Requirement (via rulemaking).

Rationale:

In 2016, CMS added a new regulation for nursing homes, the Facility Assessment to evaluate each facility's resident population. CMS further expanded this regulation on May 10, 2024, at 483.71. The expanded requirements ordered nursing homes to document in detail a variety of new topics. This is a paperwork centered requirement and can limit innovative staffing approaches in facility operations.

Additionally, the Facility Assessment requirement is duplicative, as much of the information collected overlaps with other required documentation, such as staffing plans, resident care policies, and quality assurance activities. Requiring nursing home staff to direct more of their time and attention to additional layers of paperwork takes away from staff time that is better spent focusing on resident care and quality of life outcomes.

Most importantly, there is insufficient evidence to show that facility assessments lead to better care for residents. The process does not directly impact operational improvements, making it an ineffective tool for enhancing quality. Eliminating the facility assessment requirement would streamline compliance efforts, allowing facilities to focus on what is most important: substantive activities that improve resident outcomes and quality.

Payroll-Based Journal

AHCA Recommendation: Update the CMS Payroll-Based Journal (PBJ) Policy Manual with the complete set of recommendations below to improve the reporting process and enhance transparency to consumers. (via guidance update)

Rationale:

Section 6106 of the Affordable Care Act (ACA) requires nursing homes to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. Payroll-Based Journal (PBJ) was created by CMS as a method to collect auditable and verifiable staffing data from nursing home providers. CMS posts the data, combined with census information, to be used to report to the public on the level of staff in each nursing home, as well as employee turnover. PBJ data is also used to calculate five-star ratings intended to inform consumers.

Current CMS PBJ policies are overly complex, inconsistent and detract from providing a full picture of facility staffing information to stakeholders. Improving staffing data reporting processes can alleviate unnecessary administrative work for nursing home leadership, allowing them to focus more on staff support and retention efforts.

The recommendations below are intended to improve the reporting process and enhance transparency by:

- Allowing the correction of PBJ data;
- Reporting all hours worked by employees;
- Improving how PBJ data is incorporated into the Five-Star Rating System;
- Enhancing the process for PBJ audits; and
- Providing additional training and information.

Implementing AHCA's recommendations will provide more complete and accurate information to consumers about facility staffing. Improved consistency and clarity in staffing data reporting will result in more effective use of this information for regulators, consumers, and providers.

ALLOWING CORRECTION OF PBJ DATA

<u>Recommendation 1</u>: Allow facilities a reasonable opportunity to submit corrected or missing data.

At present, PBJ policy does not allow providers to submit corrected or missing data for any reason, which is both misleading to consumers and families and unfairly punitive for facilities. According to CMS, the purpose of collecting and displaying this data in the Nursing Home Five Star Quality Rating system is "to help consumers understand the level and differences of staffing

in nursing homes". The current Five-Star staffing rating includes several scenarios where a facility would have their staffing score suppressed or downgraded:

- Providers that fail to submit any staffing data by the required deadline will receive a one-star staffing rating for the quarter.
- Providers that submit staffing data indicating that there were four or more days in the quarter with no RN staffing hours (job codes 5-7) on days when there were one or more residents in the nursing home will receive a one-star staffing rating for the quarter.
- Failing an audit results in a downgrade to one star for the next 3 months
- For the turnover measures, nursing homes that fail to submit staffing data or submit erroneous data for one or more of the quarters used in the turnover calculation will receive the lowest score possible for the corresponding turnover measures (5 points for total nurse and RN turnover; 10 points for administrator turnover).

Facilities may fall into some of these scenarios due to missing or erroneous data submission. This is not an accurate representation to the public of staff in the facility. Furthermore, the lack of ability to correct data for future, specifically for the turnover measures which utilize 6 quarters, makes this policy unnecessarily punitive as the provider is already being penalized for the quarter at hand.

Additionally, with the scheduled adoption of PBJ-based measures into the Medicare SNF Value based Purchasing Program in FY 2026, allowing for corrected PBJ data will help ensure more facilities have their Medicare reimbursement tied to accurate staffing levels and turnover. If a facility has missing or incomplete PBJ data for the VBP measurement windows, their VBP payment adjustment is determined only by other quality measures.

The SNF Quality Reporting Program (QRP) Reconsideration policy and process finalized in the FY 2016 SNF Prospective Payment System provides a fair and reasonable process for nursing facilities to follow and should be used as a model for PBJ reporting. The policy allows nursing homes to request reconsideration of an initial determination that the SNF did not comply with the reporting requirements under the SNF QRP. Here is how the SNF QRP Reconsideration policy works:

- Facilities have the ability to file a request for reconsideration generally within 30 days of the initial notification of noncompliance and are required to submit supporting documentation and evidence demonstrating their full compliance with the SNF QRP requirements.
- Facilities also have the ability to request an extension or exception and have the ability to communicate extraordinary circumstances that may have existed (as defined in the policy) to cause a failure in filing a timely request of exception (such as a natural or man-made disaster), in order to extend the 30-day deadline.

- CMS is required to notify the SNF in writing via email of its final decision for a request for extension to file a reconsideration of non-compliance.
- Finally, the policy states that if a SNF is dissatisfied with a reconsideration request decision, the SNF may file an appeal with the Provider Reimbursement Review Board.

Establishing review and reconsideration processes for PBJ reporting will provide more complete and accurate information to consumers about nursing home staffing. Improved consistency and clarity in staffing data reporting will result in more effective use of this information for regulators, consumers, and providers.

REPORTING OF ALL HOURS WORKED

<u>Recommendation 2</u>: Allow nursing facilities to report all hours worked for exempt employees using data from time and attendance record keeping, which are auditable by surveyors.

Current PBJ guidance states:

> "Facilities must submit the number of hours each staff member (including agency and contract staff) is paid to deliver services for each day worked…[I]f a salaried employee works 10 hours but is only paid for 8 hours, only 8 hours shall be reported. If a facility is paying a salaried employee a bonus for additional hours worked, those hours shall be reported under the following conditions: the payment must be directly correlated to the hours worked and must be distinguishable from other payments. (e.g., cannot be a performance-based or holiday bonus). Additionally, the bonus payment must be reasonable compensation for the services provided."[10]

This policy impacts the accuracy of hours for nearly all exempt employee job classifications unless facilities provide additional bonus payments, which are not the norm. Compensation for work should be left to the discretion of the employer, not directed by CMS PBJ policy. The policy results in many exempt employees who provide patient care (e.g., nurses) being unable to count any hours over a typical 35-40 hours worked in a week and results in significant inaccurate information for registered nurse (RN) and total nursing staffing hours per resident per day. Furthermore, the policy is particularly challenging for rural providers where nurses (including the director of nursing [DON] and administrator, who is also an RN) frequently provide care to residents to help cover shifts.

[10] Electronic Staffing Data Submission Payroll-Based Journal: Long-Term Care Facility Policy Manual at 2-5 (v. 2.6, June 2022).

It is concerning that a system meant to collect accurate staffing data uses a policy that essentially directs the underreporting of hours. The goal should be to provide an accurate picture of the care that is provided.

<u>Recommendation 3</u>: Discontinue the mandatory exclusion policy noted below and allow providers to submit all hours that employees are paid for and work.

PBJ policy requires the mandatory exclusion of 30 minutes from every 8-hour shift worked for meals or break time.[13] This policy sometimes prevents facilities from being able to report all hours worked by staff and because of this policy, facilities are not allowed to provide accurate information on staffing hours worked to the public.

For example, there are instances when an employee voluntarily works through a meal break to provide care or voluntarily works an eight-hour shift without a meal break. This CMS policy also requires facilities to take an extra step in modifying payroll hours worked to exclude the 30 minutes from actual hours worked and paid, only for the purpose of fulfilling this policy.

Compensation for work should be left to the discretion of the employer, not directed by CMS PBJ policy.

<u>Recommendation 4</u>: Allow reporting of the various staff mentioned below to fully capture the care and services provided to residents.

It should be permissible for hours for an administrator in training to be reported. Furthermore, these hours should be reported under a distinct job code in the administration services job description. This would also provide clarity and consistency to the administrator turnover measure in Five-Star.

Additionally, PBJ guidance states: "Practitioner (e.g., physician, nursing practitioner) visits to residents billed to Medicare or another payer, hours for services provided by hospice staff and private duty nurses shall not be reported."[11] These are important hours of care that are being provided to the resident that are not being accounted for or recognized. For instance, if a managed care organization or a provider network is paying for the services of a nurse practitioner to provide care to a resident, those hours cannot be reported because the facility is not paying for those hours.

We recommend CMS allow these hours to be reported by the nursing facility to provide a complete picture to consumers on the staff providing care and services to residents.

<u>Recommendation 5</u>: Allow hours for telework by RNs to be reported.

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[11] Electronic Staffing Data Submission Payroll-Based Journal: Long-Term Care Facility Policy Manual at 2-7 (v. 2.6, June 2022).

The expansion of technological advances has revolutionized how we can provide care more efficiently and effectively. For instance, rather than driving hours from patient to patient, remote RNs can take vitals, review labs, perform virtual physical examinations, and provide assessments using technology. Often, this use of telehealth enables additional access to care, especially in rural communities.

In addition, an MDS coordinator is an example of an RN role that is central to the coordination of care. They can conduct the assessment portion remotely with the help of on-site staff who remain present with the residents. The administrative portions of the documentation requirements are identical whether conducted remotely or on-site. Therefore, remote RNs such as MDS coordinators should be counted/reported.

Currently, none of these hours of care described above can be reported in PBJ. This disincentivizes innovation, fails to capture an accurate picture of the care provided, and hurts the ability to attract highly-trained nurses. Allowing these remote RNs to be captured could improve access to care for residents in remote locations or areas as well as help with recruitment and retention efforts. With a workforce shortage of such experienced professionals, this flexibility would be incredibly helpful while still assuring quality care.

INCORPORATION OF PBJ DATA IN FIVE-STAR

There are four recommendations we want to make for including PBJ data in Five-Star.

Recommendation 1: Provide an incentive for providers who have high staffing levels. Prior to adding the turnover measures, CMS allowed facilities with 4 or 5 stars in Staffing and a staffing rating higher than their survey rating to add an overall star. We recommend going back to such a structure where providers are provided with positive reinforcement for their staffing. Specifically, we recommend that providers who have a Staffing star rating of 4 or 5 add a star to their Overall Five-Star rating.

Recommendation 2: Stop forced rating downgrades to 1 star as a PBJ audit penalty. If CMS keeps the approach of forced rating downgrades, this should only be applied after the facility can correct the data discrepancy and fails to do so within a reasonable time period.

Recommendation 3: Nursing hours in Five-Star should include hours reported for nurse practitioners and clinical nurse specialists. Currently, RN hours only include: RN director of nursing (job code 5), RNs with administrative duties (job code 6), and RNs (job code 7). When sharing nursing hours with consumers, it is important that the hours of care provided by nurse practitioners and clinical nurse specialists are included because individuals with these roles are RNs who have specialized education to provide advanced care.

Recommendation 4: Number of administrators that leave the building should not include assistant administrators. The PBJ manual instructs providers to submit hours for administrators

and assistant administrators into one job code (job code 1). This means that in Five-Star, the number of administrators that leave the nursing facility over a twelve-month period includes both administrators and assistant administrators. To be clear and transparent, administrator, assistant administrator, and administrator in training should all be reported under the administration services job description but under three distinct job codes, and for Five-Star, only administrator turnover should be included in the calculation.

PBJ AUDITS

Recommendation 1: Providers should be provided with 14 calendar days to respond to a PBJ audit. CMS currently requires providers to respond to a PBJ audit within 7 calendar days. This timeframe is aggressive and does not consider that staff responsible for PBJ submissions may not be working over the weekend or could be out of the office for another reason. Additionally, it puts excessive burden on providers, especially independent operators, which detracts from patient care.

Recommendation 2: Providers should have the opportunity to engage in an exit conference before the conclusion of the audit. An exit conference provides an opportunity for the auditor to share preliminary findings with the provider and gives the provider the chance to explain or provide any final supporting information prior to the conclusion of the audit process. This enables a more collaborative audit process and can reduce the number of audit reconsideration requests.

Recommendation 3: Prompt delivery of audit results to providers. After a PBJ audit is completed, providers should promptly receive the results. Some providers have noted that they are experiencing delays of two months or more in receiving the results of their audit. CMS should require auditors to provide the formal audit results within 10 business days post audit. This would be consistent with the timeframe utilized for the delivery of 2567s.

Recommendation 4: Providers in all instances should be given an opportunity to submit a reconsideration request. There are certain instances (e.g., utilizing the same employee ID for multiple contract staff) where a provider is not given an opportunity to submit a reconsideration request. Having a blanket rule that prevents a facility from being able to submit a reconsideration request fails to take into consideration that there might be a unique circumstance that results in a minor versus significant discrepancy of actual and reported hours.

Recommendation 5: Invoices from contractors acknowledging the presence of contract staff and their hours should be sufficient to validate hours for contract staff. CMS has shared that hours may only be entered into PBJ if they are paid. Providers may have contract staff providing care to residents in their building. It is feasible that the invoices for these contractors are not received until the end of the quarter and that the payment schedule and processing of these invoices may take more than 45 days. As such, providers should be able to

submit invoices and other documentation to validate the hours of service provided by these individuals and not be required to submit proof of payment during the audit.

Recommendation 6: Increase transparency for audit approach and process.

Currently, CMS does not provide any formalized documentation explaining the audit process and requirements (including sample questions asked and requested documents). Increasing transparency of the process would enable providers to be better prepared for audits and increase the efficiency of the audit process. Additionally, it would create a standardized set of expectations and enable the identification of variance. Understanding the audit process can also help with quality improvement as providers analyze answers to the questions internally and take steps to better understand requirements.

ADDITIONAL REQUESTS

Additional PBJ Reports including:

- A report that identifies the percentage of days in a quarter that has no staffing data submitted.
- Access to accurate data in the 1705D PBJ Staffing Data Report prior to the PBJ deadline or having a similar report prior to the submission deadline that flags data with common issues such as missing employee IDs, no RN staffing, missing data for a certain timeframe within the reporting period, etc.

Additional Training including:

It would be helpful to have updated webinar-based training from CMS available to providers on:

- Steps to register to submit PBJ data
- Steps to submit PBJ data
- Use of PBJ CASPER reports
- Preparing for a PBJ Audit
- A quarterly PBJ webinar hosted by CMS to highlight common issues identified in PBJ submission and share best practices on meeting the reporting requirements.

PBJ FAQs

The PBJ Policy Manual FAQs should be updated to include additional questions and answers to support providers in submitting accurate PBJ data.

PBJ Support

Continue to improve the provider experience with the PBJ call line. Specifically, if the first contact does not resolve the issue, provide a pathway for rapid escalation so that the issue may be

resolved in a timely manner. If contact has been made prior to the deadline for support and the issue has not been resolved, allow the provider additional time to submit their data.

SNF Provider Enrollment Disclosure

AHCA Recommendation: Rescind the off-cycle SNF provider enrollment revalidation deadline of August 1, 2025, and instead:

- Require currently enrolled SNFs to provide disclosures during their next regularly scheduled five-year provider enrollment revalidation, and
- Work with SNF stakeholders to remove excessive disclosure requirements from sub-regulatory guidance that exceeds the requirements in §1124(c). Disseminate and regularly update such guidance on the CMS website and via interactive activities including webinars and office hours calls.

Rationale:

The Affordable Care Act (ACA) expanded SNF Medicare and Medicaid provider enrollment ownership disclosure requirements beyond all other provider types in § 1124(c) of the Social Security Act (the Act). The expanded SNF disclosures in § 1124(c)(2)(A) pertain to:

> *(ii) The identity of and information on—*
> *(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;*
> *(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and*
> *(III) each person or entity who is an additional disclosable party of the facility.*
> *(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.*

Additional requirements in § 1124(c)(2)(C) defines that "ownership or control interest" included direct and indirect ownership and that an owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation of the SNF property assets equal to or greater than 5 percent are also reportable.

Subsequently, the Biden Administration promulgated regulations that added SNF disclosure requirement beyond what is required in statute [88 FR 80141], particularly expanding the scope of reportable non-ownership-related additional disclosable parties (ADPs) that provides

management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

CMS then updated the CMS-855A provider enrollment form, adding a lengthy SNF-specific attachment, effective October 2024. At that time, CMS added more burdensome sub-regulatory reporting requirements and announced an off-cycle provider enrollment revalidation deadline of 90 days. This compliance deadline was later extended for all SNFs to May 1, 2025, with the warning that failure to meet the deadline would result in their provider enrollment being suspended or revoked. Then in mid-April, the deadline was extended again to August 1, 2025.

One example of the excessive disclosure burden is that there is no minimum threshold for disclosure. As CMS describes in its sub-regulatory guidance:

> *"There is no minimum threshold for disclosure in terms of: (1) the length of time the party must have furnished the services, served on an [Additional disclosable Party's] ADP's governing board, etc.; (2) the degree and extent of involvement with the SNF's day-to-day operations; and (3) the volume of the furnished services, functions, etc…Even if certain services were furnished for only a very brief period, by a temporary employee, and only one time…, disclosure is required."*

For all practical purposes, without a minimum threshold, providers believe this means that a SNF would need to report any consultant or temporary employee brought in for even one day per year by submitting a change of information (COI) provider enrollment transaction for the day they started and another for the day they stopped, even if that was the same day. This becomes even more challenging if the ADP is an employee of a third-party organizational ADP of the SNF. Given such individuals have no financial interest or responsibility for implementing disclosable activities on a day-to-day basis, we believe it is irrational for SNFs to submit COI transactions for temporary employees or consultants or front-line personnel that do not substantively impact SNF operations.

Meanwhile, we are concerned that providers are not always receiving the proper support from CMS to fulfill these additional requirements on the agency's accelerated timeline. AHCA has disseminated extensive information to our nearly 11,000 SNF members, conducted multiple webinars, and hosted 'office hours' calls to educate members. However, scores of provider questions regarding how to interpret the CMS guidance remain unanswered. Additionally, those who have submitted the off-cycle revalidations to their Medicare Administrative Contractors (MACs) are receiving limited support, inconsistent responses, and are often requested to submit additional information about the ownership, organizational structure, and employees of third-parties that are extremely difficult to obtain. As of mid-May, less than half of SNFs had submitted their revalidations due to the incredibly intense nature of the reporting and lack of clarity from CMS.

If providers are not able to meet the August 1 submission deadline, providers may have their Medicare enrollment suspended or revoked, meaning they will not be able to admit Medicare/Medicaid patients and current residents—who are often frail, older adults with multiple conditions—may need to be relocated. This burdensome reporting could create an access to care crisis. We urge CMS to rescind the revalidation deadline of August 1, 2025, and the excessive disclosure requirements that became effective October 2024.

SNF Quality Reporting Program Measures

AHCA Recommendation: Remove several SNF Quality Reporting Program (QRP) measures that do not result in better resident outcomes (via rulemaking). We are requesting the removal of several measures promulgated through rulemaking that meet the regulatory requirements for CMS to 'remove a quality measure' as stipulated in 42 CFR 413.360(b).

We recommend CMS rescind the following measures from the SNF QRP:

1. COVID-19 Vaccination Coverage among health care personnel (HCP)
2. Influenza Vaccination Coverage among HCP
3. Drug Regimen Review Conducted with Follow-Up for Identified Issues PAC SNF QRP
4. Transfer of Health (TOH) Information to the Provider (PAC)
5. Transfer of Health (TOH) Information to the Patient (PAC)
6. COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date

Rationale:

Overall, these measures should be removed because they do not result in better resident outcomes. Many of them are also inconsistent with the statute, which requires that measures be interoperable, risk-adjusted, and endorsed by an approved contractor. The failure of these measures to meet these standards as well as the fact that they are process measures makes comparing performance between providers—one of the primary purposes of the program—meaningless. Put together, the costs associated with a measure outweigh the benefit of its continued use in the program.

Removing these specific measures from QRP would help put patients over paperwork and readjust the program to focus more on the metrics that matter to patients. Providers would be able to devote more resources to improving patient care and modernizing health information exchange capabilities rather than to these administrative duties.

Updating MDS to Reflect QRP Changes

AHCA Recommendation: Remove the data elements from the Minimum Data Set (MDS) assessment associated with the SNF QRP process measures AHCA recommends for removal. These include the following measures and associated data elements:

1. Drug Regimen Review Conducted with Follow-Up for Identified Issues PAC SNF QRP MDS items:
    a. N2001 - Drug Regimen Review
    b. N2003 - Medication Follow-up
    c. N2005 - Medication Intervention
2. Transfer of Health (TOH) Information to the Provider (PAC) MDS item:
    a. A2121- Provision of Current Reconciled Medication List to Subsequent Provider at Discharge
    b. A2122 - Route of Current Reconciled Medication List Transmission to Subsequent Provider (item not listed in any measure specification, but is tied to A2121)
3. Transfer of Health (TOH) Information to the Patient (PAC) MDS item:
    a. A2123 - Provision of Current Reconciled Medication List to Resident at Discharge
    b. A2124 - Route of Current Reconciled Medication List Transmission to Patient (item not listed in any measure specification, but is tied to A2121)

Rationale:

These items capture process, as opposed to clinical assessment findings, and therefore would not be utilized to develop a person-centered care plan. These processes are documented in the medical record routinely during a patient's stay, which is also subject to review during recertification surveys.

If the QRP measures are removed as recommended, these items will no longer be necessary for an MDS assessment. Removing these data elements from the MDS would help put patients over paperwork and readjust the program to focus more on the metrics that matter to patients. Providers would be able to devote more resources to improving patient care and modernizing health information exchange capabilities rather than to these administrative duties.

Standardized Patient Data Elements

AHCA Recommendation: Remove the inclusion of Standardized Patient Data Elements (SPADEs) that are not associated with existing SNF QRP measures from the reporting requirements impacting a SNFs Annual Payment Update (APU) determination.

Rationale:

Most of the MDS data elements subject to the two percent SNF QRP APU adjustment (if a facility does not meet the compliance threshold) include data elements that are not associated with any current SNF QRP quality measure.[12]

A data element may be standardized among the post-acute care providers and not subject to the penalties associated with the SNF QRP. We are not requesting the items be removed from the MDS per se, only that they do not apply to the SNF QRP APU compliance threshold determination. While many of these MDS items are used for payment and resident care area assessment (CAA) purposes, which are already subject to those regulatory requirements, they have no identified purpose for measuring the quality of Medicare services as they are not attributed to any existing SNF QRP quality measure.

Additionally, these MDS data elements are duplicative of other reporting requirements (i.e., for PDPM reimbursement, CAAs, other CMS quality programs), putting paperwork over patients.

Therefore, we request that the data elements listed below be removed from the above-mentioned SNF QRP data elements table:

A1005 Ethnicity
A1010 Race
A1110A What is your preferred language?
A1110B Need or want an interpreter to communicate with a doctor or health care staff?
A1250 Transportation
B0200 Hearing
B1000 Vision
B1300 Health Literacy
C0100 Should Brief Interview for Mental Status be Conducted?
C0200 Repetition of Three Words
C0300A – C BIMS Interview data elements
C0500 BIMS Score
C1310A Acute Onset Mental Status Change
C1310B Inattention
C1310C Disorganized Thinking
C1310D Altered Level of Consciousness
D0150A1 – D0150I2 Resident Mood Interview Data Elements
D0160 Total Severity Score

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[12] Skilled Nursing Facility Quality Reporting Program (SNF QRP) Overview of Data Elements Used for Reporting Assessment-Based Quality Measures and Standardized Patient Assessment Data Elements Affecting FY 2027 Annual Payment

D0700 Social Isolation
GG0130A1 – GG0130H3 Self-Care Data Elements (Admission and Discharge only)
GG0170A1 – GG0170SS3 Mobility Data Elements (Admission and Discharge only)
J0510 Pain Effect on Sleep
J0520 Pain Interference with Therapy
J0530 Pain Interference with Day-to-Day Activities
K0520A1 – K0520Z4 Nutritional Approaches Data Elements (Admission and Discharge only)
N0415A1 – N0415Z1 High Risk Medications Indication and Use Data Elements
O0110A1a – O0110Z1c Special Treatments and Procedures Data Elements (Admission And Discharge only)

Streamline MDS Reporting

AHCA Recommendation: Reduce repetitive MDS data elements that typically do not change from assessment to assessment to only complete on admission (via interim final rule).

This would include removing the following MDS data elements:

- A1005. Ethnicity
- A1010. Race
- A1110. Language
- A1200. Marital Status

Rulemaking would be required to address changes for A1005 Ethnicity, A1010 Race, and A1110 Language from either a 5-day or Part A PPS MDS assessment, as they are currently required under the SNF QRP data elements. This would remove the reporting enforcement, even before any changes to the MDS item sets or technical specifications.

Rationale:

The reporting requirements in this section do not typically change from assessment to assessment. Currently, MDS coordinators are required to ask these questions and answer them for each assessment. By eliminating repetitive questions that do not change after the admission assessment, CMS can reduce reporting burden.

SNF QRP APU Reporting Exceptions

AHCA Recommendation: Permit exceptions/exclusions for the SNF Quality Reporting Program (QRP) Annual Payment Update (APU) reporting requirements for all resident interview items when providers have a 5-day PPS assessment combined with an unplanned discharge assessment (A0310B = 01, A0310F = [10, 11], A0310G = 2, and A0310H = 1).

In many cases, sufficient information is not available and cannot realistically be obtained from the resident. Such situations most commonly occur for unplanned discharges within the first 24 hours of a SNF Medicare admission before such assessments can be completed.

Rationale:

CMS provides current exceptions and permits dashed in cases of Section GG mobility and self-care items for QRP APU and the three functional outcomes quality measures (Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual, Version 6.0). In that manual, the incomplete stay exclusion definition states:

> *"Incomplete Medicare Part A SNF stays are defined based on the measure. Incomplete Medicare Part A SNF stays occur if the resident was discharged to an acute care setting (e.g., acute hospital, psychiatric hospital, or long-term care hospital), had an unplanned discharge, was discharged against medical advice, had a stay that was less than three days, or died while in the facility."*

Additionally, the CMS MDS-RAI Manual 1.19.1 resident interview coding guidance related to missed interviews and unplanned discharges also permits exceptions to completing the Brief Interview for Mental Status (BIMS) (Chapter 3, page C-2).

However, the RAI Manual does not permit a similar incomplete stay except for the PHQ-2 to 9 Resident Mood Interview (Chapter 3, page D-2) nor for the resident Pain Assessment Interview (Chapter 3, page J-5). Both domains have available staff assessment options in situations where an interview was not feasible prior to the unplanned discharge, but it is not currently allowed.

We disagree with the current CMS rationale cited in sub-regulatory open door forum calls (12/07/2023 & 12/07/2024) that such exceptions/exclusions form the SNF QRP APU are not possible because interview assessment items are required under the SNF 5-day PPS assessment. The primary purpose of the SNF 5-day assessment is for resident payment case mix classification and not as a specific SNF QRP quality outcome, as there are no admission to discharge data points to compare. Additionally, there is no financial advantage for the SNF not being able to complete a resident interview assessment for unplanned discharges as their SNF PPS case mix assignment would not receive a positive adjustment factor from the interview item value. It would be fairer to adjust the SNF PPS grouper to address the added exception to skip to the staff assessment.

Additionally, by not applying a SNF QRP APU exception/exclusion for the depression and pain assessment domains, the SNF could become subject the negative two percent SNF QRP APU adjustment for all Medicare claims for a subsequent payment year. We have heard from small providers with unplanned discharges very early into the Part A stay being subject to this unfair penalty for situations beyond their control.

Health Insurance Prospective Payment System Code

AHCA Recommendation: Allow the option for obtaining a full Patient Driven Payment Model (PDPM) Health Insurance Prospective Payment System (HIPPS) Code on OBRA MDS assessments instead of completing a separate 5-day MDS, to allow alternate payers to obtain this information if needed for billing (via policy/process update).

Rationale:

The current process, for facilities to "complete" and not submit a PPS 5-day or Interim Payment Assessment (IPA) for billing purposes, is burdensome and results in increased reporting errors. It requires the facility to complete two separate MDS assessments, most often with the same assessment reference date. In addition, many states also require an Optional State Assessment as well, resulting in three different MDS assessments, with different items and assessment periods.

It also results in the accidental submission of 5-day MDSs utilized for non-Medicare Part A stays, inappropriately impacting reporting under the SNF Quality Reporting Program (QRP) and most often requiring a Manual Deletion Request to remove the erroneous assessment from the iQIES database. A Manual Deletion Request requires the facility to contact their State RAI Coordinator/Automation Coordinator to complete a document. This document is then required to be sent via certified mail to the State, which then must manually remove the erroneous data.

To avoid this, it is recommended to add an MDS data element in Section A that would allow for the required items to generate a full PDPM HIPPS code on an OBRA MDS assessment, such as a data element that asks if this assessment will be used for PDPM payment purposes other than Medicare Part A.

ADDITIONAL RECOMMENDATIONS

Civil Monetary Penalties Reinvestment Program

AHCA Recommendation: Update the CMS CMP Reinvestment Program (CMPRP) to Improve Access to Funds to Support Quality of Care including by removing caps as well as

allowing for the consideration of innovation and workforce requests (via Guidance Update to CMPRP).

Rationale:

Under existing regulations, Civil Monetary Penalties (CMPs) are intended to be utilized to support quality improvement initiatives. The CMP Reinvestment program (CMPRP) execution has been relatively ineffective, deterring the CMP funds from being used or accessed as intended by statute. CMS should update the CMPRP policies to increase opportunities for nursing homes to access funds that support efforts aimed at improving quality of care.

Restoring access to workforce initiatives through CMP funds would provide much-needed support for recruiting and retaining nursing staff. Nursing homes continue to experience post-pandemic workforce challenges, yet since September 2023, CMPRP funds have been completely restricted from access for workforce initiatives.

Despite significant unused balances of CMP funds remaining in state accounts, CMS placed a stringent cap of $5,000 (QSO-23-23-NHs) per facility to use for meaningful resident projects. This cap does not consider the number of residents in the facility or the unique needs or characteristics of each facility. It also does not encourage innovation, which is important to finding new and better ways of providing quality care.

MDS Help Desk

AHCA Recommendation: Reopen the MDS Help Desk previously provided by CMS and provide a national RAI Coordinator Center with an MDS Help Desk to serve as the primary support for questions regarding the Resident Assessment Instrument (RAI) and MDS coding.

Rationale:

Previously, there was an MDS Helpdesk at CMS, but this has been eliminated. Restarting this support for nursing homes and publishing Frequently Asked Questions documents like those provided to long term care hospitals and inpatient rehabilitation facilities quarterly would be helpful to achieve the mutual goals of CMS and nursing homes for the MDS/RAI process.

There is much interpretation by individual State RAI Coordinators, payer sources, and other auditors regarding the coding of MDS items, especially those utilized by payment. Having universal guidance would remove this variation that could support Medicare program integrity and national quality programs.

In the past, some states often did not have an assigned State RAI Coordinator or State Automation Coordinator listed in Appendix B, which prevented facilities in that state from having a resource. Open positions in these roles have lasted for many months for some states. Experience levels of State RAI Coordinators vary, including those with no experience with completing the MDS or with Medicare reimbursement. Some respond quickly; others have multiple roles, leading to delays in responses, while some do not consistently respond at all. This has impacted MDS corrections, state rosters for Medicaid reimbursement, and timely MDS completion. Coders are hesitant to sign the attestation in Z0400 if they are uncertain whether an item is coded accurately or if there is conflicting direction among auditors, State RAI Coordinators, and the RAI Manual.

This national center could replace individual State RAI Coordinators, improving overall efficiency and effectiveness for both CMS and nursing homes in the RAI/MDS process.

SNF Claim Audits

AHCA Recommendation: Establish systems and processes in the Medicare Program Integrity Manual to prevent duplicate auditing of a SNF claim that has previously been subject to a medical necessity review finding.

Rationale:

While we recognize the purpose of various Medicare program integrity claim audit contractors including the MACs, RACs, SMRCs, CERT and other entities that review SNF claims for accurate coding and documentation supporting medical necessity. We also appreciate that CMS has established systems and processes in the Medicare Program Integrity Manual (Chapter 3, Section 3.5.2 – Case Selection) that ensure that individual claims are not simultaneously reviewed by different claim audit contractors, and purportedly, “claims that were previously reviewed”.

However, in recent years, many SNF providers are reporting that they are subject to subsequent audits of the same SNF claims by different audit contractors, often within months of each other, and often with different medical necessity audit determination findings. We recommend that (per Section 3.5.2) once a claim has been cleared as being medically necessary by the first auditor, that claim should not be subject to a subsequent medical necessity audit.

Medicare Advantage: Prior Authorizations

AHCA Recommendation: Standardize prior authorization requirements across Medicare Advantage plans to reduce burden and improve timely access to care (via rulemaking).

Rationale:

Federal regulations at 42 CFR § 422.138 and § 422.137 establish the framework for prior authorization and utilization management in Medicare Advantage (MA). These rules are intended to ensure that services are medically necessary and that MA organizations (MAOs) apply consistent criteria aligned with Medicare fee-for-service (FFS) coverage policy or established clinical guidelines. However, in practice, the implementation of MA plans' prior authorization processes has become highly fragmented and burdensome for patients and providers, particularly in skilled nursing facility (SNF) settings.

Most MA plans require prior authorization for SNF services. This often results in delays in initiating care, as services cannot begin until authorization is received or risk denial of payment, creating financial and operational uncertainty. Consequently, patients may remain in the hospital unnecessarily, contributing to increased healthcare costs and hospital capacity strain. Similar challenges and risks occur with readmissions to the SNF.

Each MA organization—and often each plan within the same organization—has its own portal, process, and documentation requirements for prior authorization and concurrent review. This variability forces providers to navigate three to 10 different MA plan systems on average, increasing the likelihood of documentation errors and delays.

A KFF report found that in 2023, MA insurers processed approximately 49.8 million prior authorization requests, of which about 6.4% (3.2 million) were denied. Notably, only 11.7% of these denials were appealed. Among those appealed, 81.7% were overturned in favor of the beneficiary.[13] This high overturn rate upon appeal suggests that many initial denials may lack sufficient justification or are due to incomplete documentation. In addition, the low appeal rate may indicate that beneficiaries often do not challenge denials—possibly due to lack of awareness or the complexity of the appeals process. This dynamic raises concerns about access to medically necessary care being hindered by administrative barriers rather than clinical appropriateness.

The burden is further exacerbated by the delegation of utilization management functions to third-party entities, which often operate with opaque criteria and limited accountability. In SNFs, the process of obtaining and maintaining authorizations—sometimes requiring updates every two to three days—places an extraordinary strain on clinical and administrative staff. This not only disrupts care continuity but also contributes to workforce burnout in an already strained sector.

These inefficiencies also have broader implications for the Medicare program and taxpayers. When care is delayed or denied due to administrative complexity, it can lead to avoidable

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[13] KFF, "Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023." January 28, 2025.

hospitalizations, higher downstream costs, and inefficient use of Medicare funds, all of which are ultimately borne by taxpayers.

Of note, as of January 1, 2024, CMS requires all Medicare Advantage plans to adhere to Medicare Part A and Part B coverage criteria, including National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and general Medicare coverage rules, as outlined in the CMS-4201-F final rule. When no applicable NCD or LCD exists, MA plans may apply internal coverage criteria, but these must be based on current clinical evidence and made publicly available. Despite this regulatory alignment, providers continue to report unclear internal criteria and inconsistent application of these rules by MA plans and their delegated entities remain a significant barrier to timely care delivery.

Under the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), effective in 2026, MA plans must respond to urgent (expedited) prior authorization requests within 72 hours and standard requests within seven calendar days. These timelines are a step forward, but for SNF services, delays of even a few days can result in unnecessary hospital stays or delayed recovery. Therefore, SNF prior authorizations should be treated as emergent to ensure timely access to care.

AHCA/NCAL Proposal

CMS should issue rulemaking to standardize prior authorization processes across all Medicare Advantage plans and their delegated entities. This should include:

- A uniform submission format and documentation checklist for prior authorization and concurrent review requests.
- Clear limitations on the use of internal plan criteria, ensuring that Medicare coverage rules are the primary basis for medical necessity determinations.
- Requirements for delegated entities to follow the same standards and be subject to CMS oversight.
- Alignment with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), including electronic prior authorization capabilities and timely response requirements.
- Designation of SNF prior authorizations as emergent, to prevent unnecessary hospital stays and ensure timely initiation of skilled services.

AHCA/NCAL supports ensuring that prior authorization processes are clinically appropriate and protect against fraud, waste, and abuse. However, the current variability across MA plans creates unnecessary administrative burden, increases the risk of technical denials, and delays access to care for beneficiaries. Standardizing these processes would:

- Improve consistency and transparency.

- Reduce the number of denials based on insufficient documentation.
- Allow providers to focus more on patient care.
- Reduce resource demands on both provider and plan staff.
- Promote more efficient use of taxpayer-funded Medicare dollars.
- Ensure seniors have timely access to SNF and Part B therapy services by treating these authorizations with urgency.

Automated Data Reporting

AHCA Recommendation: CMS should engage a stakeholder group to develop a strategic plan and provide feedback on the process of transitioning to automated health information reporting for multiple purposes across the SNF sector.

Rationale:

Given technological advances, we believe there is an incredible opportunity to automate the reporting of data by SNFs to the federal government and state agencies through seamless and more timely health information exchange. It could significantly reduce the administrative burden on regulators and providers, while providing more timely information to consumers and stakeholders. However, we believe a thoughtful and deliberate process is needed to make this transition, so that it is done safely and securely and does not inadvertently create an increased burden or result in an unfunded mandate on providers.

For example, many demographic data elements regarding beneficiary characteristics, or information related to a beneficiary's goals, preferences, and priorities could be more efficiently submitted by beneficiaries or their representatives via a digital app. That information could then be automated to populate the SNF electronic health record (EHR) or shared with CMS primarily through automated processes supplemented by SNF assessor updates, rather than conducting time-consuming assessments at every transition of care to collect data that is often duplicative.

When considering such automation, CMS will need to rethink whether:

- the current, more rigid MDS item reporting requirements and reporting schedule would align with more automated reporting processes;
- the use of artificial intelligence (AI) to curate and interpret variations in supporting documentation meets a test of being "good enough" for reporting purposes;
- human oversight will be required and verified and to what degree;
- any such automated processes are feasible in areas without adequate broadband access – and if not, what comparable manual reporting options would be available for such providers while minimizing reporting burden.

We also recommend taking a thoughtful approach to this work due to the variations in digital maturity across the SNF sector. This is directly the result of federal policymakers historically prioritizing hospital inpatient and primary care interoperability, including through the implementation of the Health Information Technology for Economic & Clinical Health (HITECH) Act of 2009 and in subsequent coordinated care, bundled care, and other integrated care value-based payment models advanced by CMS. Since long term and post-acute care providers were not specifically identified in the HITECH Act, the federal resources and administrative support necessary to facilitate seamless, secure interoperable electronic exchange of patient information to CMS, between providers, and to the patient—particularly at transitions of care—has been quite limited.

In the absence of a federal coordinated effort, SNF providers that have adopted health information technology (HIT) have instead developed non-standardized HIT, including EHRs to support setting-specific clinical and operational activities. As recently as December 2023, the federal government reported that most long-term and post-acute care providers, including SNFs, have generally adopted EHRs to support clinical and business needs at a rate comparable to hospitals and primary care providers.[14]

However, the researchers also emphasized that interoperable exchange of health information is not routine or widely used. In other words, SNF providers utilize their EHR, but modernization to improve digital maturity remains slow without focused and realistic policy levers. Despite barriers, there are opportunities for emerging policies to support secure interoperability in SNFs.

The breadth of this digital divide was also reflected in a recent report by the Office of the National Coordinator for Health Information Technology (ONC). In this report, the ONC indicated that only 17 percent of hospitals are able to routinely send interoperable health information to long term and post-acute care providers, and only 8 percent of hospitals were able to routinely receive such information from LTPAC providers.[15]

We appreciate the recent ONC efforts in launching the Trusted Exchange Framework and Common Agreement (TEFCA) to enable nationwide health information exchange that could provide opportunities for long term and post-acute care providers with nonstandard HIT to exchange information through a Health Information Exchange (HIE). However, a recent report revealed that this alternative method for information exchange will likely be insufficient to resolve the interoperability gap for our sector.[16] Specifically, thirty-two percent of the current Health Information Organizations (HIOs) that could facilitate this information exchange through

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[14] ASPE, "Health Information Technology Adoption and Utilization in Long-Term and Post-Acute Care Settings." December 18, 2023.
[15] ONC, "Interoperable Exchange of Patient Health Information Among U.S. Hospitals: 2023." May 2024.
[16] Everson, et. al., "The state of health information organizations and plans to participate in the federal exchange framework." August 21, 2024.

their HIEs have indicated they may not participate in TEFCA. This means that despite these opportunities, CMS will need to work with SNF stakeholders to consider policy efforts to attract the remaining HIOs or ensure nonparticipating HIOs' providers have another option for TEFCA participation.