July 7, 2020

Ms. Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Room 445-G  
Hubert Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

RE: Docket CMS-5531-IFC: Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program

Dear Ms. Verma:

The Association for Professionals in Infection Control and Epidemiology (APIC) wishes to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to provide input into its interim final rule revising certain Medicare and Medicaid policies and regulations in response to the COVID-19 public health emergency (PHE). APIC is a nonprofit, multidisciplinary organization representing over 15,000 infection preventionists (IPs) whose mission is to create a safer world through prevention of infection. We applaud CMS for recognizing the need for flexibility to respond to the ongoing serious public health threat posed by the COVID-19 pandemic. We especially appreciate your recognition of the important role social distancing plays in reducing transmission as evidenced by the ability to provide care and services in alternative settings, including the home, to decrease the overall risk for exposure to COVID-19.

Requirements for Facilities to Report Nursing Home Residents and Staff Infections, Potential Infections, and Deaths Related to COVID-19

APIC supports this data collection and agrees that it has the potential to be beneficial in monitoring trends in infection rates and inform public health policies. Weekly reporting of infections, deaths, personal protective equipment (PPE) supplies, ventilator capacity, resident beds, access to testing, etc. helps to inform government agencies on availability, use, and allocation of resources, infection transmission rates, community needs, and other risk factors. With this information, we can better understand this novel virus and plan for additional needs, as well as learn how to reduce transmission, and treat and protect residents and staff of nursing home facilities. However, the immediate practical utility has not been as apparent to nursing home facilities that have been struggling with inadequate PPE supplies, access to testing, and other resources as well as challenges with staffing. Further, the

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information has not been actionable at the facility level, so the time spent at this data collection has not yet been beneficial through improved support or access to critical resources.

When considering the burden of the information collection and reporting for a nursing home facility, it is important to also consider the people doing this task. Although there is a requirement for an infection prevention program and staff aligned with the program, the number of hours dedicated to the program management is generally limited and the persons in this role also have other responsibilities in the facility. Like other healthcare providers during this PHE, IPs have been stretched beyond their regular infection prevention and control routines with responsibilities to respond appropriately to the COVID-19 pandemic. IPs in nursing home facilities often do not have access to support for data analytics to electronically capture the required data elements, resulting in time-consuming manual data collection. The lack of analytic support also requires them to develop the collection and reporting tools and systems. APIC expresses concern that the pending CMS proposed rule “Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency” (Docket #CMS-3347-P, 7/18/19) seeks to change the current CMS long-term care (LTC) requirement to have an IP “at least part-time” in each facility to “sufficient time to be able to implement the facility’s infection prevention and control plan,” a subjective phrase that could result in less staff time devoted to infection prevention and control. Weekly reporting to NHSN may be challenging for a part-time staff who is also tasked with the pandemic response, as well as the other routine infection prevention and control duties within the facility.

APIC agrees with the use of CDC’s National Healthcare Safety Network (NHSN) so that the data collection burden can be reduced by consolidating requests for COVID-19 data from all agencies into one data submission. This ensures data standardization while also allowing access to the various federal and state government agencies.

APIC supports the new provision requiring facilities to inform residents, their representatives and families on information regarding COVID-19 in their facilities. Such transparency instills confidence that the facility leadership is committed to the safety of residents and will also facilitate mitigation efforts by helping staff implement infection control practices to prevent transmission of the virus. In order to reduce the reporting burden, APIC agrees with allowing reporting options to include phone calls or recorded messages, listservs, website postings and paper notification.

**Update to the Hospital Value-Based Purchasing (VBP) Program Extraordinary Circumstance Exception (ECE) Policy**

APIC agrees with the revision to the extraordinary circumstances exception policy to allow CMS to grant a waiver to hospitals located in an entire region or location without a request, as this helps alleviate the burden to hospital administration on filing a request. We recommend that CMS maintain clear communication with hospitals to avoid duplicative filing. APIC also appreciates CMS waiving requirements for NHSN reporting of healthcare-associated infection measures for Q4 2019, Q1 2020, and Q2 2020. However, we note that State regulations may continue to require this reporting, so this allowance should not be considered a reduction in burden or labor by IPs in most states.

**Delay in the Compliance Date of Certain Reporting Requirements Adopted for IRFs, LTCHs, HHAs and SNFs**

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We appreciate CMS’s postponement of the compliance date for the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP) and Long-Term Care Hospital Quality Reporting Program (LTCH QRP) to at least one full fiscal year after the end of the PHE and two years for LTCs. We also support the delay in compliance with the new transfer of health information provider post-acute care and patient post-acute care quality measures to provide sufficient time for facilities to implement and validate these measures.

APIC appreciates CMS’s efforts to provide regulatory flexibility during this PHE and we thank CMS for the opportunity to comment on the CMS measures impacting infection prevention and control.

Sincerely,

Connie Steed, MSN, RN, CIC, FAPIC
2020 APIC President