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June 16, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1622-P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection, April 20, 2015

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 850 hospital-based skilled nursing facilities (SNFs), the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) SNF prospective payment system (PPS) proposed rule for fiscal year (FY) 2016. Our comments focus on the agency's proposals for the SNF Quality Reporting Program (QRP), which will take effect for FY 2018 payment, and the SNF Value-Based Purchasing (VBP) program, which will affect SNF payment in FY 2019.

We support several of CMS's specific proposals for the SNF QRP and SNF VBP, but urge the agency not to finalize the proposed functional status measure for the SNF QRP. The measure is not endorsed by the National Quality Forum (NQF), and is duplicative of data already reported by SNFs. The implementation of this measure could lead to considerable burden and confusion, without adding value. We also urge CMS to adjust the SNF VBP readmission measure for sociodemographic factors, given the significant evidence showing the impact of issues such as income and dual-eligibility for Medicare and Medicaid on readmission rates.

Furthermore, the AHA urges CMS to use the final rule to articulate how it intends to coordinate the implementation of these two new statutorily-mandated programs with its existing quality measurement effort for SNFs, the Nursing Home Quality Initiative (NHQI). Launched in 2002, NHQI uses certain data reported by SNFs on the CMS-mandated Minimum Data Set (MDS) to calculate quality measures and report them publicly on *Nursing Home Compare*. The MDS is a key part of the mandated process SNFs must use to regularly assess and document the health status and capabilities of their patients. We appreciate that CMS



must fulfill its obligations under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act and Protecting Access to Medicare Act (PAMA) to implement SNF QRP and SNF VBP. However, we also believe all three programs must be focused on the common goals and objectives. A lack of a clearly articulated approach for coordinating these efforts across all three programs could lead to considerable confusion among SNFs, other providers and patients.

Our detailed comments on CMS's proposals follow.

SNF QUALITY REPORTING PROGRAM

The IMPACT Act requires that CMS establish the SNF QRP. SNFs that fail to meet all SNF QRP quality data submission and administrative requirements are subject to a 2.0 percentage point reduction to their annual payment update. In this rule, CMS proposes the first three measures for the QRP, as well as several other program requirements and processes.

GENERAL CONSIDERATIONS FOR IMPLEMENTING THE IMPACT ACT

The AHA strongly encourages CMS to develop and make publicly available a comprehensive plan describing how it will implement the provisions of the IMPACT Act in all of its post-acute care quality programs. The IMPACT Act is a multi-faceted law that will have significant operational impacts for SNFs, long term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs) and home health (HH) agencies. The law's requirements will involve changes to quality measures and the patient assessment tools used for each setting. A comprehensive plan would enable all stakeholders to understand whether CMS's approach works in a concerted fashion across its programs. It also would give all of the affected post-acute care providers an opportunity to plan for the potential impacts to their operations.

The AHA urges CMS to adhere to the four principles outlined below in implementing the provisions of the IMPACT Act:

- **Communicate estimated implementation timelines for all data collection and reporting requirements as early as possible.** We appreciate that CMS used the proposed rule to indicate that IMPACT Act quality measure requirements generally would be tied to payment in the fiscal year that begins two years after they are adopted in rulemaking. We encourage the agency to use its plan to identify the estimated implementation dates for specific measures and patient assessment data.
- **Use reliable, accurate, feasible and care-setting appropriate measures that are both endorsed by the NQF, and reviewed by the multi-stakeholder Measure Applications Partnership (MAP).** The IMPACT Act strongly encourages the use of NQF-endorsed measures as well as the MAP review process. We applaud CMS for engaging the MAP in an *ad hoc* review earlier this year. However, as described in greater detail below, we are concerned that two of the proposed measures for FY 2018 lack NQF endorsement.

- **Foster as much standardization of measures and data collection across post-acute care settings as possible, while recognizing that limited variations may still be necessary.** The IMPACT Act requires that CMS adopt the same measurement domains for all post-acute care QRPs, and that the measures be “standardized and interoperable” across post-acute care facilities. However, the statute does not provide specific operational definitions of these two terms. We believe how CMS interprets these terms will have significant implications for post-acute providers.

The AHA cautions that “complete” standardization and interoperability of measures – i.e., using the exact same measure specifications, data definitions and data collection tools across all post-acute settings – may not always be possible. The agency may not have NQF-endorsed measures shown to work across all four settings. Similarly, CMS may need to alter measures so they work with the data collection mechanisms of a particular care setting, or so that they focus on collecting the data most relevant to a particular patient population. In such instances, CMS instead could focus on achieving “topical” standardization in which all four post-acute care provider types report on the same measure topics, but using data collection instruments and definitions (e.g., rating scales) that may vary. To fulfill the requirement of “interoperability,” CMS could develop mechanisms to ensure the data are routinely shared across post-acute settings with crosswalks or other explanations of how the data from each setting are defined. In those instances where the agency can achieve “topical” standardization only, the agency should undertake additional measurement development activities to determine whether greater standardization is possible.

- **Minimize the burden of collection and reporting requirements.** SNFs and other post-acute care providers must balance numerous reporting requirements from CMS, private payers and others. CMS should ensure any new requirements add value and are not unnecessarily duplicative with existing reporting requirements.

PROPOSED MEASURES FOR FY 2018

CMS proposes three measures for the FY 2018 SNF QRP addressing specific measurement domains required by the IMPACT Act. All three measures would be calculated from MDS data.

Pressure Ulcers. **The AHA supports CMS’s proposal to use the pressure ulcer measure reported as part of the NHQI for the SNF QRP.** The measure assesses the percentage of short-stay (i.e., stays of fewer than 100 days) residents with stage 2 to stage 4 pressure ulcers that are new or worsened since a prior assessment. This measure is endorsed by the NQF, and also is used in the NHQI.

Falls with Major Injury. **The AHA believes the proposed fall with major injury measure could be an appropriate addition to the SNF QRP. However, we urge the agency to ensure the measure has been adequately tested on nursing home residents with stays less than 100 days, and to develop a risk-adjustment approach.** Calculated from MDS data, the measure assesses the percentage of residents that experience one or more falls with major injury. Similar to the proposed pressure ulcer measure, this measure already is used in the NHQI and is NQF

endorsed. However, it appears the measure obtained NQF endorsement for use on long-stay patients. It is not clear to what extent the measure has been tested for reliability and validity for patients whose stays are less than 100 days. If the agency has undertaken such testing, we urge that it share it in the final rule.

We also urge CMS to incorporate risk adjustment into the measure. A patient's propensity for falls is determined not only by the quality of care, but also a variety of other clinical factors beyond the control of providers, including co-morbid conditions, baseline level of functioning and so forth. Furthermore, the IMPACT Act requires that measures include risk adjustment where necessary and appropriate. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. Risk adjustment is meant to create a "level playing field" that allows fairer comparisons of whether providers are doing all they can to ensure the quality of care.

Functional Status. While the AHA agrees functional status is a critically important measurement area for SNFs and other post-acute care providers, we do not support CMS's proposed functional status measure. We are concerned the new measure duplicates existing SNF data reporting requirements, and would lead to significant burden and confusion.

In general, functional status measures assess the extent to which patients regain the ability to perform activities (or "functions") essential to daily living, such as self-care and mobility. CMS specifically proposes to adopt a version of a functional status assessment measure the agency finalized last year for use in LTCHs. The measure reports the percentage of patients with a functional status assessment completed at admission and discharge, as well as at least one documented goal addressing function. Clinicians would be required to numerically score (using a six-level rating scale) the level of independence that patients demonstrate on several assessment items, including self-care, mobility, cognition and communication. Additionally, clinicians would be required to record a numerical functional goal score at admission for at least one of the mobility or self-care items.

CMS proposes to add new functional status assessment items to the MDS to enable the calculation of the measure. However, we are concerned that these items would be collected in addition to – and not in place of – the existing functional status items on the MDS. SNFs already are required to collect and report functional status items on the MDS for reimbursement purposes. The existing MDS items also use different rating scales than the proposed measure. Thus, CMS's proposal effectively asks SNFs to report data on the same topics in two different ways. We are concerned such an approach would add significant data collection burden, and could lead to inaccurate coding of resident function for both measurement and payment purposes. Indeed, SNF providers would be confused as to which way of assessing function is considered the "source of truth" for care planning purposes.

Instead of implementing duplicative reporting, the AHA recommends that CMS develop a plan to revise the existing MDS function items so they are more consistent with data collected in other post-acute care facilities. This would allow the agency to meet the requirement that SNFs report functional status data, while laying the groundwork for a measure

that is more “standardized” and “interoperable” across post-acute care setting. Such a transition would require considerable analysis to ensure there are not negative unintended consequences for SNF reimbursement, and testing in SNF facilities to ensure the revised instrument collects accurate, reliable and meaningful data.

SNF VALUE-BASED PURCHASING PROGRAM

The PAMA requires CMS to establish a VBP program for SNFs beginning in FY 2019. The SNF VBP program must tie a portion of SNF Medicare reimbursement to performance on either a measure of all-cause hospital readmissions from SNFs, or a “potentially avoidable readmission” measure. In this rule, CMS proposes an all-cause hospital readmission measure it intends to use in the SNF VBP program. The agency also solicits input on several SNF VBP implementation issues it intends to address in future rulemaking.

Readmission Measure. **The AHA strongly urges CMS to adjust its proposed readmission measure for sociodemographic factors before it is implemented in FY 2019.** CMS proposes to use the SNF 30-day All-Cause Readmission Measure (SNFRM) in the SNF VBP program. Calculated using Medicare claims data, the measure assesses the risk-adjusted rate of all-cause, all-condition, unplanned hospital readmissions for SNF patients within 30 days of a “prior proximal acute hospitalization.” CMS defines a prior proximal acute hospitalization as an inpatient admission to an inpatient prospective payment system hospital, a critical access hospital or an inpatient psychiatric facility. The measure reflects both the readmissions of patients readmitted to the hospital directly from the SNF, and patients discharged from the SNF but readmitted to the hospital before the end of the 30-day measurement timeframe.

Unfortunately, the SNFRM like CMS’s other readmission measures, fails to adjust for sociodemographic factors outside the control of the hospital – such as the availability of primary care, mental health services, easy access to medications and appropriate food. Mounting evidence shows that socioeconomic factors significantly influence the likelihood of a patient’s health improving after hospital discharge or whether a readmission may be necessary. These community issues are reflected in readily available proxy data on sociodemographic status, such as Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. We urge CMS to consider using these data to apply sociodemographic adjustment to the SNFRM.

Other SNF VBP Program Considerations. In the proposed rule, CMS solicits input on a variety of SNF VBP implementation issues that it intends to address in future rulemaking. The AHA addresses two of those issues below.

- **Performance Standards and Scoring.** The PAMA requires CMS to establish numerical performance standards for the SNF VBP. In establishing these standards, CMS must recognize SNFs for the higher of “achievement” compared to other SNFs or improvement in their own baseline performance. **The AHA encourages CMS to establish the performance periods standards before the beginning of the performance period.** The agency uses this approach for the hospital VBP program, and it allows providers to

understand in advance what level of performance they must achieve to perform well in the program.

- **Measuring Improved Performance.** CMS discusses several policy options for rewarding SNFs for improved performance. The agency outlines the potential use of the hospital VBP's scoring approach where hospitals receive points for both improvement and achievement. Under this method, the hospital's score is then translated into an incentive payment using a simple linear exchange function. The agency also contemplates rank-ordering SNFs, and rewarding those who improve their ranking relative to other SNFs. The agency also is considering whether improvement points should be rewarded to SNFs that improve by a certain target percentage (e.g., by 25 percent).

The AHA recommends the agency adopt a scoring approach very similar to that of the hospital VBP program. CMS has ample experience with the hospital VBP program to operationalize the approach with SNFs. Moreover, of the options CMS is considering, this approach provides the strongest incentive for all SNFs to improve performance. Indeed, the linear exchange function means that both low- and high-performing SNFs have the same marginal incentive to improve performance.

Thank you for the opportunity to comment on the proposed rule. If you have any questions, please contact me or Akin Demehin, senior associate director of policy, at (202) 626-2365 or ademehin@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President