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June 26, 2017

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

RE: CMS-1679-P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for Fiscal Year 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, SNF Team Composition, and proposal to Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020.

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 803 hospital-based skilled-nursing facilities (SNFs) and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2018 proposed rule for the SNF prospective payment system (PPS). In this letter, we urge CMS to delay the reporting requirements for the standardized patient assessment data elements; we also request more insight into any empirical modeling used to inform the implementation proposals for the SNF Value-Based Purchasing (VBP) program. In a separate letter, we will respond to the Advance Notice of Proposed Rulemaking regarding the revisions to the case-mix methodology, as the comment period for this document has been extended to August 25.

SNF Quality Reporting Program (SNF QRP)

The Affordable Care Act mandated that reporting of quality measures for SNFs begin no later than FY 2014. Failure to comply with SNF QRP requirements will result in a 2.0 percent reduction to the SNF's annual market-basket update.



CMS proposes four new measures, the replacement of one measure, and the modification of another measure for the FY 2020 SNF QRP. In addition, CMS would require SNFs to collect certain standardized patient assessment data beginning with SNF admissions on or after Oct. 1, 2018 to meet additional IMPACT Act requirements.

While the AHA appreciates that the proposed measures are intended to address significant patient health outcomes, AHA urges caution in their implementation and suggests that CMS provide standardized and in-depth guidance regarding how measures should be collected and calculated. Furthermore, CMS's proposal to report standardized patient assessment data is too much, too soon, and we believe the data elements require further testing prior to implementation. Therefore, we urge CMS to delay its proposal to report standardized patient assessment data for at least one year.

FY2020 Measurement Proposals

Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury. **The AHA urges CMS not to adopt this measure for the SNF QRP until it has conducted further testing around the inclusion of unstageable pressure ulcers and deep tissue injuries (DTIs) in the measure calculation.** The SNF QRP already includes a measure examining the percentage of patients that have new or worsened pressure ulcers. Yet CMS would replace this measure with one that asks SNFs to capture data on both "stageable" pressure ulcers (i.e., those that can be assigned a numerical score of 1 to 4), and unstageable pressure ulcers, including DTIs, assessing which ones at each stage are unhealed. CMS suggests this change is appropriate because it would capture a fuller range of skin integrity issues. CMS further posits that this measure would help the agency meet its IMPACT Act mandate to implement "interoperable measures" across post-acute care (PAC) settings because this same measure is proposed for other post-acute settings.

However, the AHA is concerned that the definition of pressure ulcers included in the measure may be too subjective to collect reliable, accurate measure data across SNFs and other PAC providers. As a result, the measure could provide misleading portrayals of SNF performance. As CMS admits in the proposed rule, there are few studies that provide information regarding the incidence of unstageable ulcers in PAC settings. In addition, there is no universally accepted definition for DTIs; in fact, studies have shown that a significant proportion of DTIs are initially misdiagnosed as stage 1 ulcers or other dermatological diagnoses with similar symptoms that are not intended to be captured by this measure. As a result, the measure may be subject to surveillance bias in which providers have higher rates of DTIs because their surveillance systems are more sensitive to capturing them.

Furthermore, the AHA also is concerned that the measure change would result in artificial distinctions between SNFs that are attributed solely to the way injuries are counted, not in the quality of care provided. Notwithstanding the lack of standardized definitions of and approaches to assessing DTIs and unstageable pressure ulcers, CMS believes one of the benefits of implementing this revised measure is that it would increase the variation in measure scores

across providers, “thereby improving the ability to discriminate among poor- and high-performing SNFs.” However, the purpose of changing a measure is not to create performance variation. Rather, any measure changes should be rooted in evidence that specifications are inconsistent with current science, or that specifications need further clarity to ensure consistent data collection across providers.

Thus, the AHA strongly urges CMS to undertake additional testing of the measure to ensure it consistently collects accurate data. We believe this testing should assess whether the measure is subject to surveillance bias and other unintended consequences that could affect how SNF performance is reported.

The AHA also urges CMS to make substantive plans around their promised “additional training opportunities and educational materials” prior to implementation. CMS is proposing significant changes to the measure data collection approach. Rather than assessing the number of new or worsened pressure ulcers at each stage (as in the current measure), CMS would ask SNFs to count the number of unhealed pressure ulcers at each stage and subtract the number present upon admission. We believe excluding those pressure ulcers that are present on admission is an appropriate improvement to the measure, but it adds complexity in coding that will be essential to explain to SNFs. Furthermore, SNF performance on the revised measure will likely look quite different from the current measure. Thus, CMS should prepare consumer-facing educational materials explaining why SNF performance is different.

Application of inpatient rehabilitation facilities (IRF) Functional Outcome Measures. **The AHA urges CMS to provide standardized training and guidance in regard to the implementation of these measures across all PAC settings.** Currently, SNFs are responsible for reporting 42 different quality measures, which they report for several different programs. While these measures are similar, they are not identical. For example, last year CMS added section GG to the Minimum Data Set. The items in this section are similar to those in section G of the tool in how they are defined and collected, but they do require the assessment of new elements. One of our large SNF members estimates that these additional items, which must be collected upon admission and discharge, increase the time to complete an assessment by 15 minutes. With the addition of these functional outcome measures, in addition to the standardized patient assessment data to be added (addressed later in this letter), SNF patient assessment activities are growing exponentially complex.

To mitigate this complexity while working towards the IMPACT Act’s goals of standardized and interoperable quality measures and patient assessment data, CMS should ensure that the same set of definitions is used to complete these patient assessment items in each PAC setting. Without guidance, providers across settings collect and calculate data for these measures differently; these discrepancies could result in unintended consequences when these data are publicly reported or tied to payment (as in value-based purchasing programs).

Potentially Preventable 30-Days Post-Discharge Readmissions. **The AHA supports the modification to this measure that would expand the data reporting period for SNFs from**

one year to two years of claims data. As CMS notes in the proposed rule, this change would better align the SNF measure with that used in long-term care hospitals (LTCH) and IRFs and would increase the sample size of cases to be used in calculating the measure. We note that extending the reporting period will exacerbate the lag between data collection and calculation of the measure, but believe that the improvement in reliability afforded by this change is more beneficial than the lag is harmful.

Standardized Patient Assessment Data Reporting

In addition to requiring standardization and alignment of quality measures, the IMPACT Act also requires the collection of standardized patient assessment data. The reporting of these data is a requirement of the PAC quality reporting programs; as a result, failure to comply with the requirements would result in a 2.0 percent payment reduction. In an attempt to facilitate data sharing and comparisons across PAC settings, CMS proposes to introduce the required reporting of standardized data elements into each setting's respective assessment tools; for the SNF setting, this would entail the addition or expansion of several data elements in the Minimum Data Set (MDS). Specifically, the agency would require SNFs to collect data on functional status, cognitive function, medical conditions, impairments, and several types of special treatments and services. While PAC providers would fulfill the FY 2019 requirement by reporting data elements already implemented in the various quality reporting programs (namely, those used to calculate the Percent of Residents or Patients with Pressure Ulcers that are New or Worsened, Short Stay), SNFs would be required to report data based on several new elements starting on October 1, 2018.

The AHA believes the implementation of these data elements is too much, too soon. We urge CMS to delay the reporting of the data elements by at least one year (i.e., to allow the reporting of elements associated with the Pressure Ulcer measure to fulfill the FYs 2019 and 2020 requirements), and to carefully assess whether all of them are necessary to meet the IMPACT Act mandate.

Validity and Reliability of Elements. Most of the proposed 23 data elements already exist in the MDS; however, the majority of these are not present in the patient assessment tools in other PAC settings and would be added to those tools (the LTCH CARE Data Set and the IRF Patient Assessment Instrument) according to other proposed rules. In addition, six of the items that are currently reported in the MDS would be expanded to include additional sub-elements that SNFs would be required to complete. CMS purports that the use of these elements in the MDS and the testing in the Post-Acute Care Payment Reform Demonstration (PAC PRD) are sufficient to show that collection and comparison of these elements across all PAC settings is feasible and that the elements will result in valid and reliable data. Unfortunately, the PAC PRD results were significantly impacted by small sample sizes, and the reliability of many data elements was poor. Thus, it is difficult to rely on results from that project to judge the integrity of the proposed data elements. In addition, for several of the elements, the precise items or sub-items CMS proposes

to add have not been tested in the PAC PRD or another PAC setting; rather a similar or related item was deemed close enough and thus appropriate for implementation.

We understand the statutory requirement for CMS to implement standardized patient assessment data elements across PAC settings, but the evidence cited in the proposed rule is not sufficient to prove that these elements are appropriate and comparable across all PAC settings. Considering that providers are asked to report on these 23 data elements for admissions and discharges beginning in just over a year, and that failure to report would result in a significant decrease in their market basket update, **we believe that CMS has not provided sufficient evidence that these data elements are ready for inclusion in the SNF QRP.**

Burden on Providers. As mentioned previously, CMS's proposal would add new data elements or sub-elements to the already lengthy MDS. **Because many of these elements have multiple parts (i.e., a principal element and 2-7 sub-elements or questions), this could result in more than 19 additional tasks for a SNF to complete.** While any one task may not take a long time to complete, the addition of all of these elements at once would change a SNF provider's workflow considerably.

In fact, CMS is currently engaged in multiple contracts to develop several additional standardized patient assessment data elements for future years in PAC QRPs. Unless CMS is planning to significantly reduce the current reporting burdens on PAC providers, it is unrealistic to mandate that providers comply with an exponentially growing list of reporting requirements. We also are gravely concerned about SNF providers' ability to reconfigure their databases and electronic health records by April of 2018 to comply with these reporting requirements. For these reasons, **we strongly urge CMS to delay implementation of these new data elements.** Because the IMPACT Act requires the collection of standardized patient assessment data for fiscal year 2019 and each subsequent year, CMS could consider data already reported in a standardized manner across the various PAC settings to be sufficient for FY 2019 and FY 2020. CMS proposes that reporting of the elements used to calculate the Pressure Ulcer measure, which has been implemented in all four PAC settings, would satisfy the statutory requirement; AHA suggests continuing this approach for an additional year to allow for further consideration of the additional data elements.

SNF QRP Public Reporting for CY 2018

CMS proposes to report data publicly in CY 2018 for three assessment-based measures and three claims-based measures. The claims-based measures were those adopted in the FY 2017 SNF final rule, and include:

- Medicare Spending Per Beneficiary;
- Discharge to Community; and
- Potentially Preventable 30-Day Post-Discharge Readmissions.

The AHA voiced several concerns regarding these measures when they were first proposed, some of which were addressed in final rulemaking. Some issues remain, and given that the measures will be reported publicly next year, it is imperative that these measures present an accurate portrayal of provider performance. For this reason, we encourage CMS to continue considering the following recommendations.

Sociodemographic Adjustment. The AHA believes SNF performance on all three measures may be impacted by sociodemographic factors. We urge CMS to assess each measure for the impact of such factors, and incorporate sociodemographic adjustment where necessary.

The evidence continues to mount that sociodemographic factors beyond providers' control – such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services – influence performance on outcome measures. Most recently, this connection was clearly shown in a report to Congress from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and in the National Academy of Medicine's series of reports on accounting for social risk factors in Medicare programs. These reports provide evidence-based confirmation of what hospitals and other providers have long known: patients' sociodemographic and other social risk factors matter greatly when trying to assess the quality of health care providers.

Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment into the quality measurement programs for SNFs and other PAC providers. Failing to adjust measures for sociodemographic factors when necessary and appropriate can adversely affect patients and worsen health care disparities because the penalties divert resources away from hospitals and other providers treating large proportions of vulnerable patients. It also can mislead and confuse patients, payers and policymakers by shielding them from important community factors that contribute to worse outcomes. Thus, **we urge CMS to incorporate sociodemographic risk adjustment for these outcome measures.**

Medicare Spending per Beneficiary for SNFs (MSPB-SNF). The AHA urges CMS to evaluate carefully the MSPB measure's clinical risk adjustment approach. We encourage the agency to work with providers to explore the feasibility of incorporating an adjustment for patient functional status. We believe patient functional status is an important determinant of patient outcomes. CMS could examine whether reliable information on functional status could be collected from claims data. In addition, given that SNFs and other post-acute care providers are required by CMS to collect information on functional status as part of patient assessments, CMS should explore whether it is feasible and not overly burdensome to providers to incorporate information from these assessments into the risk model.

Discharge to Community. The AHA urges CMS to assess carefully the reliability and validity of patient discharge codes used to calculate the discharge to community measure. The measure assesses the percentage of Medicare fee-for-service (FFS) patients discharged from SNFs to home or home health care (i.e., "community discharges") with no unplanned rehospitalizations or deaths within 31 days of discharge. CMS would identify community discharges using patient

discharge status codes recorded on Medicare FFS claims. However, as noted by MedPAC and in other published studies, patient status discharge codes often lack reliability. Given that they are so integral to the calculation of the discharge to community measure, CMS should test the measure to ensure it provides an accurate portrayal of performance.

Potentially Preventable Readmissions (PPRs). The AHA has long urged that readmission measurement focus on those readmissions that are truly preventable, so we applaud CMS for proposing to remove the duplicative all-cause unplanned readmissions measure from the SNF QRP. However, we urge continued evaluation of the PPR measure. In particular, the categories and lists of “potentially preventable readmissions” should be based on careful evaluation by clinical experts and detailed testing. We appreciate that a technical expert panel was consulted on the list of categories and codes of readmissions considered “potentially preventable.” However, we strongly encourage CMS to undertake additional empirical testing to ensure there is evidence that the codes actually are associated with the identified categories.

Future Considerations for the SNF QRP

In addition to proposing expansions and modifications to the SNF QRP for proximal program years, CMS also invited public comment on the importance, relevance, appropriateness, and applicability of quality measures for future years in the SNF QRP. We appreciate the opportunity to provide input on these longer-term proposals, and hope that CMS incorporates our and others’ comments thoughtfully as they further develop the SNF QRP.

Development of Experience of Care Survey-Based Measures. **The AHA has long favored the use of patient experience surveys as tools to help providers improve the engagement and satisfaction of patients and their families. However, the proliferation of questions on such surveys has resulted not only in substantial costs to providers to collect the data, but also a significant burden to patients.** Indeed, many patients have expressed frustration to our members about the length of surveys and the amount of time it takes to complete them. It is critical that surveys include a parsimonious set of questions so that valuable patient time and finite provider resources are used efficiently and effectively.

We urge that any patient experience of care survey for SNFs be carefully aligned with other surveys to reduce duplicative collection activities. A patient’s course of care often crosses multiple care settings and providers within a given time period, and the Consumer Assessment of Providers and Systems (CAHPS) program has surveys for nearly every setting. Indeed, CAHPS includes surveys for physicians, hospitals, nursing homes, dialysis facilities and home health agencies. Patients who receive care in two or more of these settings could receive multiple surveys. Typically, surveys are not distributed until days or weeks after a patient has received their care. This may create confusion about which provider or facility is actually being assessed. A patient may inadvertently attribute a positive or negative experience to the wrong provider.

In addition, we would like to note that CMS has proposed to amend the pain-related questions in the HCAHPS to concern communication about pain rather than experience of pain. We encourage CMS to align any new experience of pain measures in the post-acute setting to this approach, which seeks to address pain without inadvertently incenting the use of opioid medications.

The AHA also strongly recommends that CMS explore the development of more economical survey administration approaches for patient experience surveys, such as emailed or web-based surveys. While we appreciate the value of assessing the patient experience across the care continuum, the use of multiple surveys means more time spent by patients to answer surveys, and more resources expended by providers to administer them. Moreover, for the purposes of CMS reporting programs using CAHPS tools, providers are permitted to use only two survey administration modes – mailed surveys and telephone surveys. Mailed surveys are relatively inexpensive to administer, but often suffer from low response rates and a significant time lag. Telephonic surveys typically yield a higher response rate and provide more timely results, but are much more expensive to administer.

Modification of Discharge to Community Measure. **The AHA supports the modification to this measure, which would exclude baseline nursing facility residents from the calculation.** As CMS notes, these residents did not live in the community prior to their SNF stay and thus would not necessarily be expected to return “successfully” to the community following discharge as specified in the measure. This modification would more accurately portray the quality of care provided by SNFs while controlling for factors outside of the SNF’s control.

IMPACT Act Measures on Transfer of Information. **The AHA urges CMS to be cautious in their development of these Transfer of Information measures, and only adopt the measures once they have received National Quality Forum (NQF) endorsement.** The measures under development include “Transfer of Information at Post-Acute Care Admission, Star or Resumption of Care from Other Providers/Settings” and “Transfer of Information at Post-Acute Care Discharge to Other Providers/Settings and End of Care.” We agree that the transfer of information between and among PAC settings is vital to ensuring safe and high-quality patient care; however, these measures are still in the early stages of development.

When they were considered by the NQF’s Measure Application Partnership (MAP) in January of this year, the public comment period had closed only a month earlier. The specifications of the measure lacked information on the modes of information transfer and failed to take pre-admission screening requirements that are already in place for SNFs into account. The MAP voiced concerns that the measures did not ensure that the information being transferred was standardized or provided in a sufficient manner to benefit the patient’s care, and many participants of the MAP worried that this process measure would not yield any useful information that would result in improvements in care or patient outcomes.

As noted in the proposed rule, CMS intends to specify these measures no later than Oct. 1, 2018 and begin data collection on or about April 1, 2019. If these measures cannot pass the NQF

endorsement process prior to those dates, **we urge CMS to delay implementation of these measures until they receive endorsement.**

SNF Value-Based Purchasing (VBP) Program

The Protecting Access to Medicare Act (PAMA) of 2014 requires CMS to establish a VBP program for SNFs beginning in FY 2019. The 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. A funding pool will be created by reducing each SNF’s Medicare per-diem payments by 2 percent; however, the Act states that only 50 to 70 percent of the total pool will be distributed back to SNFs in the form of incentive payments. In this proposed rule, CMS proposes several program details regarding the determination of performance scores and incentives as well as other administrative policies.

The AHA requests that CMS provide more insight into any empirical modeling used to inform its implementation proposals. The cursory explanations provided in the proposed rule do not afford sufficient transparency into the processes used to determine important program logistics; additional details should be provided in the final rule.

Transition from All-Cause to Potentially Preventable Readmissions. **The AHA supports the transition from the all-cause readmissions measure to the potentially preventable readmissions measure in FY 2021, if not sooner.** As a prerequisite to implementing the SNF VBP program, CMS adopted the all-cause, all-condition hospital readmission measure in the FY 2016 SNF PPS final rule (referred to as SNFRM). The following year, CMS adopted an all-condition, risk-adjusted potentially preventable hospital readmission measure for SNFs (referred to as SNFPPR). PAMA requires CMS to apply the latter measure instead of the former “as soon as practicable.” In the proposed rule, CMS states that FY 2021 would be the first opportunity to make the transition; **AHA requests additional background on how CMS made the determination of this timeline.**

The AHA believes that the SNFPPR measure is preferable to the SNFRM as its focus on readmissions that could be reasonably avoided more accurately reflects the quality of care being provided in SNFs rather than random chance. However, **we believe that the SNFPPR measure should continue to be monitored for unintended consequences, and that CMS should consider additional provisions to account for socioeconomic and other social risk factors.** In this proposed rule, CMS requests feedback on how to account for these risk factors in the SNF VBP program; we recommend incorporating the strategies suggested in the 2017 ASPE Report to Congress on *Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs*.

One strategy that AHA would support is developing readmission measures and/or statistical approaches to report performance specifically for beneficiaries with social risk factors. As the ASPE report noted, analyses show that beneficiaries at high social risk are much more likely to be re-hospitalized during the first 30 days of a SNF stay; in addition, beneficiaries who stay at

SNFs that serve a high proportion of beneficiaries with social risk factors are more likely to be re-hospitalized in the same time period. This suggests that the SNFPPR measure outcomes could vary significantly due to factors outside of a SNF's control.

Change in Rounding Methodology. Currently, SNF performance scores are rounded to the nearest whole number. CMS explains in the proposed rule that this methodology results in an “insufficiently precise” outcome, including a significant number of tie scores. Clusters of providers around scores make it difficult to determine the distribution of performance outcomes among all 16,000-plus SNFs in the program. Because of these challenges, CMS proposed to instead round performance scores to the nearest ten-thousandth of a point.

We agree that rounding to the nearest whole number does not truly reflect differences in the quality of care provided, so we support this amendment to the methodology. However, as CMS moves forward with the VBP program—including development of measure specifications and scoring methodologies—we caution against any changes that are implemented only to result in more differentiation among providers. **Measures should only be changed to reflect updated intelligence on what constitutes the highest quality of care, not to artificially create separation among providers based on mathematical constructs.**

Logistic Exchange Function. CMS proposes to use an “exchange function” to translate performance scores into value-based incentive payment percentage updates. CMS modeled several functions and determined that “the logistic function maximized the number of SNFs with positive payment adjustments... [and] that the logistic function best fulfills the requirement that the SNFs in the lowest 40 percent of the ranking receive a lower payment rate than would otherwise apply, resulted in an appropriate distribution of value-based incentive payment percentages, and fulfilled the other statutory requirements.”

The AHA does not necessarily oppose the use of a logistic exchange function, and agrees that more SNFs receiving positive payment adjustments is a beneficial outcome of the program. However, we are concerned about the lack of details on the outcomes of CMS's modeling provided or hyperlinked in the proposed rule. CMS neglects to share the actual inputs (only noting that they used “historical SNFRM data”) or outcomes of their model, and does not provide insight into how the SNFPPR measure would influence the distribution of incentives under this particular function. The AHA understands that the exact function used will depend on the distribution of scores during the performance period, but **we request additional details on CMS's consideration of potential exchange functions including the years of performance data used and the precise functions modeled so that we may better understand the connection between performance and payment.** In addition, we suggest that CMS perform a “dry run” with their proposed methodology and provide confidential feedback reports to SNFs to demonstrate how they would fare in the exchange function model.

60 Percent Payback. By law, only 50 to 70 percent may be distributed back to SNFs in the form of incentive payments, with the exact percentage to be determined by CMS. **The AHA requests additional details on how CMS arrived at the conclusion that 60 percent is the appropriate**

percentage of the funding pool to pay back to SNFs in the form of incentive payments.

While we believe that the SNF VBP should be budget neutral, we understand that CMS is restricted by law to only pay back between 50 and 70 percent of the funds. We do not necessarily oppose the 60 percent payback, and we support CMS's proposal to revisit this plan as the SNF VBP program progresses; however, there is very little information on how or why CMS believes this to be the appropriate amount.

Extraordinary Circumstances Exception. The AHA believes that the SNF VBP program should adopt an Extraordinary Circumstances Exception policy to afford administrative relief from program requirements for providers suffering from circumstances beyond their control. As noted in the proposed rule, such an exception is provided in other value-based purchasing programs; thus, we recommend that the policy as adopted in the SNF VBP program should be aligned with that used in the Hospital VBP program.

We thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Caitlin Gillooley, associate director of policy, at cgillooley@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development