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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—1696—Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 800 hospital-based skilled-nursing facilities (SNFs), the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2019 proposed rule on the SNF prospective payment system (PPS).

In addition to other changes, this rule proposes a complete redesign of the SNF PPS in FY 2020. **The AHA appreciates the extensive work CMS has done to develop an alternative to the current SNF case-mix system.** As noted in the rule, the current system has been widely criticized by policymakers for overly concentrating payments on cases with high-therapy utilization. As an example, the Government Accountability Office found that Medicare payments for therapy greatly exceed SNFs' costs for therapy. In addition, the Medicare Payment Advisory Commission (MedPAC) found that "...almost since its inception, the SNF PPS has been criticized for encouraging the provision of excessive rehabilitation therapy services." In response to these concerns, following five years of research, CMS presented the resident classification system (RCS-I) in the agency's 2017 advanced notice of proposed rulemaking. After receiving extensive comments on the advanced notice, CMS created a subsequent iteration, the patient-driven payment model (PDPM), which this rule proposes for implementation in FY 2020.

The AHA supports the PDPM design in that it would increase overall payment accuracy for SNF patients, especially for the medically complex patients treated at



disproportionally high rates by hospital-based providers. However, our evaluation of the PDPM found that the model still has several flaws, which must be addressed before the PDPM proposal can be finalized. We appreciate CMS's engagement with the field in developing the PDPM. Specifically, we are pleased to have been involved in two of the CMS technical expert panels (TEPs) used to collect input during its extensive research and development period. Further, we appreciate CMS's responsiveness to incorporating many recommendations from the field in the second iteration of its reform model. However, as noted, failure to correct certain issues would make the already difficult transition to a complex new model even more challenging, and in some regards, impossible. **Therefore, we have concerns about proceeding to implement the model before further collaboration with stakeholders can occur to address the remaining PDPM issues, including finalizing a comprehensive implementation plan.**

THE PDPM WOULD ADVANCE HOSPITAL-BASED SNFs' IMPORTANT ROLE

We commend CMS for creating a classification system that would sustain and build upon the unique strengths of hospital-based SNFs. While they represent a small portion of the overall SNF field, hospital-based SNFs play an important role in the continuum of care. In fact, they have many attributes that policymakers have been striving to make more prominent across the overall SNF field, as evidenced by the following data from MedPAC:

- In 2016, hospital-based SNFs were disproportionately represented among those SNFs with the highest shares of medically complex patients and had notably lower shares of intensive therapy days (61 percent) compared with freestanding facilities (83 percent).
- Over the past six years, hospital-based units had community discharge rates that were higher than those of their freestanding counterparts, and in 2013 were 6.6 percentage points higher.
- In 2015, hospital-based SNFs provide more staffing, higher-skilled staffing and shorter stays (discussed more below) in order to provide quality care for their more severely ill patient population.

Lower Average Length of Stay (ALOS) for Hospital-based SNFs. While they treat a more severely ill patient population, hospital-based SNFs have a far shorter ALOS than that of freestanding SNFs – an attribute being pursued by SNF partners in alternative payment models (APMs). Specifically, with regard to Medicare fee-for-service days per beneficiary receiving services, hospital-based patients received an average of 17.8 days of care, while patients in a swing bed received an average of 11.0 days and freestanding SNF patients received an average of 27.5 days (CMS Program Statistics, Calendar Year (CY) 2015). This far-lower ALOS is not only desirable to policymakers, but also aligns with the efficiency goals sought under APMs, such as bundled payment and accountable care organizations.

Persistent Negative Medicare Margins for Hospital-based SNFs. The extremely negative Medicare margins of hospital-based SNFs (see Table 1) reflect the additional resources needed by their sicker patient population – only a portion of these heavily negative

margins are due to other factors, such as health system cost allocation. Such negative margins, in part, would be mitigated by the PDPM model, which would help sustain this important setting. The margin data below are derived from MedPAC (CY 2013 and FY 2016 margins) and AHA analysis of HCRIS data (FY 2014 and 2015 margins).

Table 1: Hospital-based SNF Medicare Margins, 2013 – 2016

CY 2013	FY 2014	FY 2015	FY 2016
-70.0%	-63.9%	-65.0%	-67.0%

THE COMPLEX PDPM REQUIRES FURTHER DEVELOPMENT

While the AHA supports the PDPM as an appropriate replacement for the current system, we are concerned about the issues raised below. **We urge CMS to undertake further model refinement in collaboration with stakeholders before finalizing the PDPM implementation plan.**

The PDPM's Complexity May Offset Intended Burden Reduction. The PDPM, with its five case-mix elements, is far more complex than the current payment model. Rather than continuing to set payments largely according to minutes of therapy, PDPM payments would be based on a compilation of five components – physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nursing, and non-therapy ancillary (NTA) services – each with unique and relatively complex criteria and case-mix adjusters. Because the PDPM proposal also materially affects the patient assessment process, it would bring a historic transformational shift to the SNF field.

Current SNF patient assessment requirements are considerable. First, we note that the minimum data set (MDS) patient assessment tool is approximately 100 pages long. Next, MDS assessments are currently mandated on days 5, 14, 30, 60, and 90 of a SNF stay, along with other required Medicare assessments. With this in mind, we appreciate the administrative simplification proposal to reduce this process to a single, mandatory assessment, the 5-day assessment using the MDS patient assessment tool. **However, we believe it is likely that this drop in administrative burden may be more than offset by new complex forms under PDPM**, such as the proposed use of ICD-10 coding and the new interim payment assessments (IPA), which would be used to reclassify patients to a new per-diem rate due to a qualifying change in their clinical status. Both of these issues are further discussed below.

IPAs Should Reset the Variable Payment Schedule. The AHA appreciates CMS's proposal for an IPA to re-assign patients to a new per-diem rate when a substantial change in the patient's clinical profile occurs after the 5-day assessment. Specifically, the proposed

policy would allow an IPA to reclassify a patient if at least one of these initial case-mix elements changes and would cause a payment change:

- A change in patient's assignment to one of the four clinical categories used to classify the patient in PT and OT case-mix groups;
- A change in the patient's status relative to the three clinical categories used to assign a SLP case-mix group;
- A change in the patient's status relative to the 25 nursing case-mix groups; and
- A change relative to the 50 conditions and extensive services used to classify the patient in an NTA case-mix group.

However, we are concerned that the framework above could require SNFs to conduct almost daily assessments to determine when an IPA is required.

In addition, we are concerned that CMS failed to propose that following an IPA a patient's variable per-diem payment schedule would not be reset. Rather, CMS is proposing that following an IPA, the patient's variable payment schedule would continue on the existing schedule with no recognition of the change in clinical status that triggered the IPA. Under the proposed variable payment policy, certain elements of the per-diem payment (the PT, OT and NTA elements) would be reduced following the initial period in the SNF to account for costs that typically decline during a SNF stay. Specifically, for PT and OT, the per-diem payment reduction process begins on the 21st day of service, with NTA reductions beginning on day 4. The schedule for these per-diem payment reductions, which increase as the length of stay increases, would not be reset by an IPA.

This misalignment between a patient's change in clinical status, as recorded on the IPA, and proposed variable payment policy could result in higher-cost IPA adjustments, such as the addition of a high-cost NTA, being underpaid. For example, the payment increase to account for a new drug initiated by an IPA would be adjusted (lessened) to maintain the variable payment schedule already in effect. In other words, even though the patient's clinical status warrants a new, high-cost medication, the variable payment reduction would not recognize this change and could underpay the new drug. This misalignment could produce negative, unintended issues, such as discharge to a hospital to cover new NTA costs or a reluctance to admit patients with conditions known to have fluctuating NTA needs. **To prevent this problem, we urge CMS to change the current proposal to instead reset the variable payment schedule following an IPA, which would help align payments and costs.**

Limitations of the 5-Day Assessment. Another concern regarding the proposed patient assessment plan, is that a great deal of additional weight – likely too much – would be placed on the 5-day assessment, relative to the current, multi-assessment process. Under the PDPM, the initial 5-Day PPS Assessment would be used to classify a patient and establish per-diem payment for the entirety of SNF stay, unless an IPA occurs. **However, securing clinician sign off and all needed medical information in time for a 5-day assessment will be very challenging.** Furthermore, such detailed coding often requires the

results of specific lab and test results not performed by or readily available to SNFs at the point of admission. For example, hospitals often discharge patients to SNFs on Friday evenings when clinical professionals can be difficult to reach.

An Alternative is Needed to the Proposed Use of ICD-10 Codes. Based on the concerns discussed below, the AHA recommends that an alternative be found to CMS's proposed use of ICD-10-CM and ICD-10-PCS codes on the MDS to classify patients in the PDPM. Specifically:

- If implemented, a burdensome process will be required to coordinate the transmission of ICD-10-CM and ICD-10-PCS codes from the inpatient hospital to the receiving SNF, as complete codes may not be available at the time of transfer. The codes often would not be available to the SNF in a timely fashion for a variety of reasons including the referring hospital's need to validate any interim code assignment, pending resolution of physician queries for specificity, interpretation of test results or for resolution of conflicting documentation from different providers.
- For FY 2019, there are nearly 79,000 ICD-10-PCS procedure codes and nearly 72,000 ICD-10-CM diagnosis codes. Much of the detail provided by these codes is irrelevant for purposes of categorizing patients under PDPM.
- SNFs have no experience with ICD-10-PCS procedure codes which are required under the HIPAA code set standards only for hospital reporting of inpatient procedures.
- SNF coding and billing staff do not have extensive coding training, which increases the probability of provider error. The risk of error is magnified by the typical lack of interoperable health system linking SNFs to their referral source.
- ICD-10-PCS is not an easy code set to learn as it requires extensive knowledge of human anatomy, understanding of unique ICD-10-PCS definitions of root operations and coding guidelines.
- Not only is the initial ICD-10 coding training extensive and complex, as demonstrated by inpatient hospitals, SNF coders would require refresher training in human anatomy and medical terminology in addition to specialized training on ICD-10-CM and ICD-10-PCS *prior to the rollout* of ICD-10-CM and ICD-10-PCS in FY 2020. For hospital coders, ICD-10-PCS procedure codes were considered the most difficult to learn as the codes are completely different from ICD-9-CM procedure codes.
- Correct selection of ICD-10-PCS codes requires understanding of the objective of the surgical procedure performed which is a difficult, if not impossible, task without a complete operative report and other medical record documentation available at the transferring hospital.
- The MDS is not a HIPAA standard electronic transaction and therefore CMS should not require ICD-10-CM or ICD-10-PCS coding for PDPM.
- Based on member input, the AHA believes that payers and auditors should have no expectation for a patient treated in both a general-acute care hospital and SNFs to have the same principal diagnosis for both settings. These two services, when provided in sequence, represent related but often distinct stages in the patient's evolving plan of care; and for both, the patient must meet admission criteria that are unique. For example, if a patient is admitted to the hospital for a stroke, the hospital would code for

acute stroke (e.g., code I63.9). If the patient then receives SNF care for the hemiplegia that resulted from the acute stroke, a different code (e.g., I69.351) would be used.

Based on these concerns, we urge CMS to identify an alternative to using ICD-10-CM and ICD-10-PCS codes for categorizing a resident into a PDPM clinical category, such as the “checklist approach” under development by other SNF stakeholders. Our understanding of this checklist alternative is that it would simplify the extensive list of codes into a relatively small and reasonable list of discrete clinical groupings explicitly applicable to physical therapy, occupational therapy, speech and language pathology and non-therapy ancillary components required to classify a patient for payment under the PDPM. Any such checklist alternative should include the following:

- Detailed instructions to accompany the conditions and comorbidities on the checklist to enable staff to understand exactly what conditions or procedures are included.
- A hierarchy for conditions that have overlapping components. For example, for PDPM Clinical Category (Table 14 in the rule) the checklist includes as separate items “Acute Infections” and “Pulmonary.” CMS should proactively specify how cases like acute pneumonia should be counted, i.e., whether providers should count this condition under both acute infections and pulmonary, or only one of these.
- Definitions of the NTA conditions (Table 27 in the rule). For example, for “severe skin burn or condition,” the definition should specify the degree of burn that would be considered severe and whether the percentage of body area burnt is a qualifying criterion.

Ensuring Adequate Payment for NTAs for Higher-acuity Patients. We are pleased that the PDPM includes a distinct NTA component, which the current system lacks. NTAs can play an important role for those patients with higher acuity, which account for a greater proportion of the hospital-based SNF patient population. Under the PDPM, an NTA payment increase would be applied for patients with any of the 50 conditions and extensive services found to drive greater costs. For each of these items, a score would be assigned, with costlier items having a larger score. Each patient’s combined score assigns the patient to one of six NTA tiers ranging from a tier with zero NTA points to the highest tier with an NTA score of 12 or more points. Given the lack of history with an NTA case-mix element and likely shifts in admissions and treatments under the PDPM, we urge CMS to closely monitor PDPM’s payments relative to NTA costs and to make adjustments, as needed, to achieve payment accuracy for NTAs. This would help overcome a long-recognized shortcoming of the current model. If the PDPM is unable to achieve accurate payment of NTAs or other costs associated with medically complex patients, CMS also should revisit the potential of adding a high-cost outlier mechanism to the SNF PPS, in alignment with prior MedPAC and stakeholder recommendations.

In addition, we are concerned that the PDPM may reduce access to care for certain patient groups. In particular, under the proposed variable rate system that tapers payments for PT, OT and NTAs, payment levels for medically-complex patients with high-cost needs could, over time, drop to a level that fails to cover the cost of care. Patients with conditions

known to require longer stays and NTAs, such as costly medications or medical equipment, could face access challenges due to tapering payments under the proposed variable payment policy that could drop payments below the cost of care. **To prevent any such barriers to access, CMS should identify and study such high-cost conditions and their projected NTA utilization, and share such findings prior to launching the new model. Following implementation, this population also would warrant ongoing monitoring. In addition, we ask CMS to provide far greater detail about the appeals process that will be available to help patients retroactively address shortcomings in their care and coverage, including any inaccurate assignments to payment classifications at any point during a stay, and to ensure a robust appeals process.**

Ensure Periodic Recalibration of the PDPM. As currently proposed, the PDPM does not incorporate a provision for periodic recalibration of the system to account for subsequent behavior changes and to ensure payment accuracy moving forward. However, the scope of the shift to PDPM, with its significant complexity and likely impact on SNF operations, certainly warrants periodic recalibration. **Therefore, in alignment with other Medicare fee-for-service payment systems, such as the inpatient PPS, we urge CMS to develop a plan for periodically re-calibrating and re-weighting the PDPM, which would also account for changes in clinical practice, technical developments, and the impact of alternative payment models.** Such periodic updates also would help address any flaws in the model that result in inaccurate payments, which could contribute to problems with access and quality of care.

Transitional Support, Provider Education and Training. The complexity of the PDPM requires timely and comprehensive training. **As such, we request CMS to proactively explain to providers and other stakeholders its full rollout plan, including addressing planned changes to sub-regulatory guidance.** Given the entirely new PDPM elements, such as the IPAs and ICD-10 coding, the SNF field needs extensive and early support to mitigate a difficult transition.

Smaller and rural SNFs, including swing-bed providers, will likely need extra transitional support. In general, these providers have fewer resources to support a complex payment system transition. Specifically, CMS Program Statistics for CY 2015 show that 54 percent of admissions to hospital-based SNFs and 90 percent of admissions to swing beds occurred in SNFs with fewer than 50 beds. In contrast, only 5 percent of admissions to freestanding SNFs were to providers of this small size. Further, many of these smaller organizations are located in rural areas, which are already under financial stress. Therefore, we urge CMS to ensure that it provides clear guidance and support to make certain that smaller and rural facilities can sustain sound, high-quality operations.

SNFs also will need to ensure that they have the technology infrastructure and vendor support necessary for a successful transition to a new SNF payment model. Experiences in acute care hospitals highlight the substantial amount of time needed to proactively ensure timely, comprehensive and reliable communication with providers and technology vendors about finalized measurement and reporting protocols. Specifically, providers need time to:

- Ensure vendor readiness;
- Adequately train staff;
- Optimize workflows;
- Update related systems; and
- Account for other processes needed for successful change management.

CMS's Projected Burden Reduction and Savings. We question CMS's projection that the PDPM proposal would yield cost savings of \$12,000 per SNF. Rather than producing savings, it seems likely that the new model may require equal or more staff time to operate, especially in the early transition years. Specifically, the time and costs associated with updating policies and procedures to align with new admissions, patient assessment, coding, reporting and other related changes, training staff on these changes, and the potential need for new personnel at many sites may be substantial. For example, more highly-skilled MDS coordinators and other administrative staff likely would be required to implement the proposed ICD-10 diagnostic and procedure codes, which could be difficult given that MDS work is already reported to present difficulty to human resources recruiters. **Based on these concerns, we recommend CMS re-examine its estimation in light of the agency's "patients over paperwork" and related administrative simplification efforts.**

Link to APMs and IMPACT Act Changes. We recognize that the PDPM's greater linkage of payments and patient characteristics aligns with the direction of other post-acute care payment reforms, such as pending, statutorily-mandated home health payment reforms, the Improving Medicare Post-Acute Care Transformation (IMPACT) Act-mandated, in-development post-acute care PPS, and the broader movement to APMs, such as bundled payment. However, we note that, thus far, CMS has not elaborated upon how the proposed implementation of the PDPM fits with these payment reform initiatives. Thus, we also ask the agency to address how the PDPM aligns with these concurrent policy development and reform efforts.

SNF QUALITY REPORTING PROGRAM (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 percentage point reduction to the SNF's annual market-basket update. In this rule, CMS proposes to alter how two existing measure rates are calculated for public display, to begin publicly displaying data on four measures, and to update the SNF Value-based Purchasing (VBP) program.

FY2020 MEASUREMENT PROPOSALS

Change in Publicly Displayed Measure Rates. CMS proposes to increase the number of years of data used to calculate the publicly displayed rates of two measures on *Nursing*

Home Compare. Instead of calculating rates based on one year of data, CMS would use two years of data to calculate the publicly displayed measure rates for the Medicare Spending per Beneficiary (MSPB) and Discharge to Community (DTC) measures. The agency argues that using two years of data would increase the number of SNFs with enough data adequate for public reporting. **While the AHA agrees that using two years of data to calculate rates is more likely to capture the intended data, we question the usefulness of a measure that needs such a significant adjustment in collection methods to acquire data necessary to calculate a rate.**

Proposed New Measure Removal Factor for Previously Adopted SNF QRP Measures. In previous rulemaking, CMS finalized seven factors to determine whether a measure should be removed from a QRP on a case-by-case basis. For FY 2019, CMS proposes to add an eighth removal factor: “the costs associated with a measure outweigh the benefit of its continued use in the program.” CMS defines “costs” as those affecting providers and clinicians as well as the costs to the agency associated with program oversight. The agency also reiterates that the measure removal evaluation process would continue to be done on a case-by-case basis, and measures that are considered burdensome or “costly” might be retained in the QRP if the benefit to beneficiaries justifies the reporting burden. **The AHA supports the long overdue addition of this measure factor to the removal criteria.**

CY 2020 Public Reporting. CMS proposes to begin publicly reporting data in CY 2020 for four assessment-based measures for which data collection begins on Oct. 1, 2018. The measures, which were finalized in the FY 2018 SNF PPS final rule, include:

- Change in self-care score;
- Change in mobility score;
- Discharge self-care score; and
- Discharge mobility score.

The AHA voiced concerns regarding the adoption of these four measures in the SNF QRP when they were proposed in 2017. Specifically, these measures are actually applications of inpatient rehabilitation facility (IRF) measures, meaning they are defined and specified for IRFs and did not receive National Quality Forum (NQF) endorsement for the SNF setting. In response to these concerns, CMS noted that they plan to submit these four measures for endorsement after one full year of data collection. **We encourage CMS to reconsider the proposal to publicly report rates for these measures in CY 2020 if these measures do not receive NQF endorsement before that time.**

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 last year's final rule, CMS adopted its proposal that 60 percent of the pool will be distributed back to SNFs. In this proposed rule, CMS proposes several program details regarding adjusted scoring methodologies for low-volume SNFs and to add an extraordinary circumstances exception policy to the SNF VBP program.

Extraordinary Circumstances Exception (ECE). The AHA appreciates and supports the proposed adoption of an ECE policy for the SNF VBP program 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 agree 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 Rochelle Archuleta, director of policy, at rarchuleta@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy