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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-1645-P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for Fiscal Year 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research.

Dear Mr. Slavitt:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 847 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) 2017 proposed rule for the SNF prospective payment systems (PPS). This letter addresses CMS's research on new payment models for SNFs and the quality-reporting provisions in the proposed rule.

SNF PAYMENT MODELS RESEARCH

The SNF PPS proposed rules for FYs 2015 – 2017 discuss CMS's work with its contractor Acumen, LLC, to develop new payment models for the SNF PPS. This work initially focused on identifying a new way to pay for therapy service under the SNF PPS, with an emphasis on paying for therapy based on the clinical need of the patient, rather than by the minutes of therapy reported by a SNF. However, the scope of this research has expanded to look at broader reform of the SNF PPS.

The AHA supports CMS's efforts to improve payment accuracy for SNFs. In particular, we encourage full consideration of the SNF PPS refinements that have been recommended by the Medicare Payment Advisory Commission (MedPAC), such as the following, which we believe will improve the fairness of payments for hospital-based SNFs:

- Pay for SNF services based on patients' clinical characteristics rather than on therapy utilization;
- Add a per-stay, high-cost outlier policy to the SNF PPS; and
- Establish a separate payment for non-therapy ancillary services, which are often required by medically complex patients.

MedPAC states that their recommended refinements would have the effect of moving payments from SNFs with high Medicare margins to those with lower Medicare margins, which include hospital-based SNFs.

In its work to develop a new SNF PPS model, we ask CMS to consider the unique and positive characteristics of hospital-based SNFs, as identified by MedPAC. First, while the shortcomings of the SNF payment system continue to result in favorable selection of higher-margin rehabilitation patients over medically complex patients, it is the hospital-based facilities that are disproportionately represented among the top-quartile of SNFs with the highest shares of medically complex patients. Also note that, despite the continued growth in payments for intensive therapy patients as a portion of the total SNF case mix, hospital-based facilities had notably lower shares of intensive therapy days (59 percent) compared with freestanding facilities (82 percent). Hospital-based SNFs also showed better quality outcomes than their freestanding counterparts, with higher community discharge rates (by 6.6 percentage points) and lower readmission rates (by 2.1 percentage points).

While only a small segment of the SNF field, hospital-based SNFs already have the high case mix being sought by policymakers for the overall field, and their unique role should be recognized and supported. We note that while the extremely negative Medicare margins of hospital-based SNFs (negative 70 percent according to MedPAC) are partly due to their higher cost structure, they are also due to the greater medical needs required by their low-margin, medically-complex case mix. **We encourage CMS to support hospital-based SNFs' continued treatment of higher proportions of a medically complex patient mix, in lieu of higher-margin intensive therapy patients, through SNF PPS refinements that appropriately recognize their important role.**

Lastly, in conducting its SNF PPS research, CMS formed two technical expert panels (TEPs) in 2015 on which AHA participated. This proposed rule notes that CMS expects its research contractor to convene a third TEP in the near future to study a potential future SNF PPS payment model. The AHA supports this effort and appreciates the transparency CMS has provided to the field regarding its research process and results.

SNF QUALITY REPORTING PROGRAM (SNF QRP)

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act requires that CMS establish the SNF QRP. Starting in FY 2018, SNFs that fail to meet all SNF QRP quality data submission and administrative requirements are subject to a 2.0 percentage point reduction.

CMS proposes four new measures for the SNF QRP to meet the requirements of the IMPACT Act. Three of the measures would be added to the FY 2018 SNF QRP, while one would be added for the FY 2020 program. The IMPACT Act is intended to foster greater standardization and alignment of measures across CMS's post-acute care quality reporting programs, including the SNF QRP.

FY 2018 MEASUREMENT PROPOSALS

CMS proposes three new measures for the FY 2018 SNF QRP – Medicare spending per beneficiary, discharge to community, and potentially preventable readmissions. All three measures are calculated using Medicare claims data, and do not require the submission of additional data by SNFs. **While the AHA appreciates that CMS proposes these measures to fulfill its statutory requirements under the IMPACT Act, we believe all three need significant improvement prior to their implementation.** We first comment on several issues pertaining to all three measures, then provide measure-specific comments.

Overarching Measure Issues.

Measure Testing. **The AHA strongly urges that all three measures be tested for reliability and validity, and that full information about measure testing be made publicly available prior to implementation. Furthermore, we urge that the measures undergo field testing with providers – prior to implementation.** The draft measure documents provided on CMS's website provide a variety of information about the measure cohorts, exclusions and risk adjustment variables that are proposed for the measures. However, the draft specifications provide limited data that would enable the field to evaluate measure design decisions. For example, there are few descriptive statistics showing the distribution of performance by characteristics like bed size or urban/rural status. There also is a lack of information on the level of statistical significance of the variables chosen for most of the risk adjustment models.

Given that the measures will be publicly reported, it is imperative that they provide an accurate portrayal of provider performance. For this reason, CMS must ensure that each measure is fully tested, and that the results of that testing are fully transparent so that all stakeholders have an opportunity to suggest meaningful improvements to the measure. Indeed, these data also would be expected to be submitted as part of the National Quality Forum (NQF) endorsement process, and the AHA strongly recommends that all measures in CMS programs receive NQF endorsement prior to implementation.

In addition, we recommend CMS conduct a "dry run" in which all SNFs are given confidential preview reports of their performance prior to publicly reporting the measure. CMS has used dry runs in the past – including in its post-acute care quality reporting programs – for new measures so that providers can become familiar with the methodology, understand the measure results, know how well they are performing, and have an opportunity to give CMS feedback on potential technical issues with the measures. Given the relative novelty of all three measures in the SNF QRP, we believe a dry run would be a crucially important step to enhancing

the understanding and credibility of the measures.

Socioeconomic Adjustment. **The AHA believes SNF performance on all three measures may be impacted by socioeconomic factors. We strongly urge CMS to assess each measure for the impact of such factors, and incorporate socioeconomic adjustment where necessary.** For example, in submitting the proposed measures for NQF endorsement, the agency could take advantage of the NQF's socioeconomic adjustment "trial period." As part of the trial period, NQF is asking for measure developers to conduct a conceptual and empirical analysis of the impact of socioeconomic status on measure performance when measures are submitted for NQF review.

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. For example, in January 2016, the National Academy of Medicine (NAM) released the first in a planned series of reports that identifies "social risk factors" affecting the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. Through a comprehensive review of available literature, the NAM's expert panel found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures, such as readmissions, costs and patient experience of care. These community issues are reflected in readily available proxy data on socioeconomic status, such as U.S. Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. The agency also recently adopted a proposal to provide an "interim" adjustment for sociodemographic factors for several measures in the Medicare Advantage Star Rating program. Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment into the quality measurement programs for SNFs, hospitals and other providers.

We are concerned that without socioeconomic adjustment, providers caring for poorer and sicker patients will appear to perform worse on some outcome measures than others treating a different patient population. Indeed, measures that fail to adjust for sociodemographic factors when there is a conceptual and empirical relationship between those factors and the measure outcome lack credibility, unfairly portray the performance of providers caring for more complex and challenging patient populations, and may serve to exacerbate health care disparities.

More Frequent Measure Data. **We encourage CMS to consider providing measure data to SNFs on a more frequent basis, such as quarterly.** For most of the claims-based measures used in CMS's programs, the agency gives providers performance data on an annual basis. However, to make effective use of the measures to improve performance, SNFs and other providers need timelier data to understand whether interventions are having an effect. Thus, we encourage the agency to explore the feasibility of more frequent performance reports on all three measures.

Medicare Spending per Beneficiary for SNFs (MSPB-SNF). The AHA urges CMS to carefully evaluate the MSPB measure's clinical risk adjustment approach. In particular, 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 carefully assess 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 re-hospitalizations 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 appreciates that CMS has proposed a measure that is intended to focus on those readmissions that are preventable. Nevertheless, we urge additional testing and evaluation of the measure prior to implementation.** The proposed measure assesses the risk-adjusted rate of unplanned PPRs to short-stay acute care hospitals and long term care hospitals in the 30 days after SNF discharge. The measure includes only those patients whose SNF stay was preceded by a "prior proximal" acute care hospital stay in the 30 days prior to SNF admission.

The AHA has long urged that readmissions measurement focus on those readmissions that are truly preventable, and we appreciate the overall intent of the measure. However, we urge continued evaluation of the 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 TEP was consulted on the list of categories and codes of readmissions considered "potential preventable." However, we encourage CMS to undertake ongoing empirical testing to ensure there is evidence that the codes actually are associated with the identified categories.

Lastly, the AHA urges CMS to review the various readmission measures used across its post-acute measurement programs to ensure they create consistent improvement incentives across the system. We note that the QRPs for SNFs, inpatient rehabilitations facilities (IRFs) and home health agencies, as well as the SNF value-based purchasing (VBP) program, all include finalized or proposed readmission measures. While the basic construction of the measures is similar, there are some important differences. For example, while CMS has proposed

post-discharge PPR measures for SNFs, IRFs and long-term care hospitals, the agency uses a readmission measure in the SNF VBP that assesses readmissions in the 30 days following acute care hospital discharge. The agency also has proposed a "within stay" readmission measure for IRFs. Yet to date, there has not been an assessment of whether the differences in measurement across these providers facilitate readmission reduction efforts. Given the value and importance of readmission reduction, we encourage CMS to work with post-acute care providers, hospitals and other stakeholders to evaluate whether the readmission measurement is being structured in a way that helps, and not hinders, effective collaboration.

FY 2020 MEASUREMENT PROPOSAL

Drug Regimen Review with Follow-up on Clinically Significant Issues. **The AHA urges CMS to provide a more specific definition of "clinically significant issues" in the drug regimen review measure. We are concerned that a lack of this specific definition will make it challenging to collect reliable and accurate measure data.** The proposed measures assesses the percentage of SNF stays for which all of the following things are true:

- Drug regimen review was conducted at the time of admission;
- *For clinically significant issues identified at admission*, the SNF contacted a physician (or physician-designee) by midnight of the next calendar day and completed prescribed/ recommended actions in response to the identified issues; and
- *For other issues identified during SNF stay*, the facility contacted a physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified.

To report the measure, SNFs would be expected to complete three items on the SNF Minimum Data Set (MDS) that reflect the above activities. However, the items themselves provide no specific indication of what issues may be considered clinically significant. The measure specifications provided by CMS also do not concretely define a "clinically significant" drug issue. Without these definitions, there are likely to be variations in measure performance that are not based on differences in care, but rather on differences in data collection.

SNF QRP PUBLIC REPORTING

The AHA supports CMS's proposed procedures for the public reporting of SNF QRP data. Specifically, the agency would use a two-step approach to allow SNFs to review and correct data. First, for measures submitted using the SNF MDS, CMS proposes to provide monthly reports that show a SNF's performance on the measures. SNFs would be permitted to correct underlying MDS assessment data up until the data submission deadline. After the submission deadline, the data would be "locked," and SNFs would not be permitted to change underlying data. SNFs would then have a separate 30-day preview period prior to the public reporting of SNF QRP data. The preview reports would include both MDS and claims-based measure data. While SNFs would not be permitted to change underlying data, they would have an opportunity to contest incorrect measure calculations.

SNF 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 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. A pool of funding will be created by reducing each SNF's Medicare per-diem payments by 2 percent. However, by law, only 50 to 70 percent of the total pool may be distributed back to SNFs as incentive payments, which will be applied as a percentage increase to the Medicare per-diem rate.

NEW SNF POTENTIALLY PREVENTABLE READMISSION (SNFPPR) MEASURE

In the FY 2016 SNF PPS final rule, CMS adopted the SNF all-cause readmission measure that the agency plans to use in the FY 2019 SNF VBP program. However, given the PAMA requirement to use a "potentially avoidable readmission" measure as soon as is practical, CMS proposes the SNFPPR measure. **As with the PPR measure proposed for the SNF QRP, the AHA appreciates that CMS is proposing a measure intended to focus on preventable readmissions. However, we urge CMS to consider adjusting the measure for socioeconomic factors. We also urge that the categories and codes used to identify PPRs undergo additional testing.**

Furthermore, we are concerned that the design of the measure differs slightly from that of the SNF QRP's readmission measure. We urge CMS to consider using a single measure for both the SNF VBP and SNF QRP. The SNFPPR assesses the rate of unplanned PPRs within 30 days of discharge from a SNF. The construction of the SNFPPR is very similar to that of the PPR measure proposed for the SNF QRP program. However, the measure differs in two key ways. First, the SNFPPR measure assesses both post-discharge PPRs as well as PPRs occurring during a SNF stay. Second, the measure includes one additional category of PPR – inadequate prevention of injury. As noted in the previous section of this advisory, the use of multiple readmission measures has the potential to create confusion, rather than encourage improvement. We believe the agency should assess the readmission measures used across its programs to ensure they are working in concerted fashion to reduce readmissions.

SNF VBP SCORING METHODOLOGY

The AHA supports CMS's proposed scoring approach for the SNF VBP program. CMS proposes an approach very similar to that of the hospital VBP program in which it determines SNF performance using the higher of a SNF's improvement versus its own baseline performance or its achievement versus CMS-determined performance standards.

SNF VBP REVIEW AND CORRECTIONS

The AHA supports CMS's proposed process for allowing SNFs to review their SNF VBP performance, and submit corrections if necessary. Similar to the SNF QRP, CMS would use a two-step approach. First, CMS proposes to provide quarterly confidential feedback reports that includes numerator and denominator data, as well as the national readmission rate. SNFs would have 30 days to request corrections. CMS also would provide another opportunity 60 days prior

to the start of the fiscal year to preview performance. While SNFs would not be permitted to request changes to underlying claims data used to calculate performance, they would have an opportunity to contest incorrect measure calculations.

We thank you for the opportunity to comment on this proposed rule. If you have any questions concerning our comments, please feel free to contact Rochelle Archuleta, director for policy, at rarchuleta@aha.org, regarding the research-related comments, or Akin Demehin, senior associate director, regarding the quality-related comments, at ademehin@aha.org.

Sincerely,

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