

August 25, 2017

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

CMS—1686—ANPRM, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-Mix Methodology

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) advance notice on potential future refinements to the SNF prospective payment system (PPS).

The AHA appreciates the extensive work done by CMS to develop an alternative to the current SNF case-mix system, which utilizes current clinical groupings known as “resource utilization groups” (RUGs). The current RUG system has been widely criticized by policy makers for creating a distribution that is overly concentrated in the RUGs with the highest payments for therapy services, even though this does not match the clinical profile of the SNF patient population. Further, as noted in the rule, the Government Accountability Office found that Medicare payments for therapy greatly exceed SNFs' costs for therapy. In addition, also as noted in the rule, 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.” **As such, we are pleased that the alternative system, known as the resident classification system (RCS-1), would improve payment accuracy for cases with higher clinical acuity, which are disproportionately treated in hospital-based SNFs.**

In addition, we are pleased to have been involved in CMS's five-year effort to develop this system. The AHA participated in the technical expert panels that provided guidance to CMS and its contractor, Acumen LLC. **While the AHA supports the broad direction of RCS-1, we encourage CMS to first address key elements of the model that still**



require further development prior to proposing implementation of the new model.

The specific areas that still require further policy work, which should be developed through collaboration with the field, are outlined far below.

THE RCS-1 MODEL WOULD PROMOTE IMPORTANT ROLE HOSPITAL-BASED SNFS PLAY

Hospital-based SNFs play an important role in the continuum of care. As noted by MedPAC, they have many attributes that policy makers have been striving to make more prominent across the overall SNF field. For example, MedPAC found that, in 2015, 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). In addition, hospital-based units had community discharge rates that were higher than those of their freestanding counterparts by 6.6 percentage points in 2013, and had readmission rates that were lower by 2.1 percentage points in 2014. Further, in 2015, MedPAC found that 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.

We commend CMS for working toward a classification system that has the potential to sustain and build upon these hospital-based SNF strengths. In particular, we are pleased that RCS-1 includes a non-therapy ancillary (NTA) component, which the RUGs lack. As noted above, 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.

Another way to examine the unique patient population in hospital-based SNFs is through SNF claims data grouped into 3M's All Patient Refined DRGs (APR-DRGs) and further broken down by severity of illness (SOI) levels. These data also show that hospital-based SNFs play a unique role in the continuum of care by treating sicker patients than do freestanding SNFs. In analyzing the fiscal year (FY) 2014 and 2015 SNF Medicare Provider Analysis and Review (MedPAR) files, we find that hospital-based SNFs have a statistically significantly higher percentage of patients in the two higher-level SOI categories (3=major and 4=extreme) than do freestanding SNFs. In FY 2015, hospital-based SNFs treated 33 percent of their patients in SOIs 3 and 4 compared with 27 percent in freestanding SNFs. In FY 2014, the rate of high-acuity cases in hospital-based SNFs was consistently high with 32 percent of all patients in SOIs 3 and 4.

Average length of stay (ALOS). It is notable that, while they treat more severely ill patient population, hospital-based SNFs do so with a far shorter ALOS than that of freestanding SNFs – another attribute that policy makers have been striving to make more prominent across the overall SNF field. 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, CY 2015). This far-

lower ALOS is not only desirable to policy makers, but also aligns with the efficiency goals sought under alternative payment models (APMs) such as bundled payment and accountable care organizations.

Margins. As noted above, the RCS-1 would improve payment accuracy for cases with higher clinical acuity, which are disproportionately treated in hospital-based SNFs. This is particularly important given the extremely negative Medicare margins of hospital-based SNFs (see Table 1), which reflect the additional resources needed by their patient population, with a portion of these heavily negative margins due to other factors, such as health system cost allocation. These data are derived from MedPAC (CY 2013 margin) and AHA analysis of HCRIS data (FY 2014 and 2015 margins).

Table 1: Hospital-based SNF Medicare Margins, 2013 – 2015

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

THE COMPLEX RCS-1 MODEL WOULD BENEFIT FROM FURTHER DEVELOPMENT

The RCS-1 model, with its four key payment domains and sub-domains, is far more complex than the RUGs. As such, it provides a broader scope and balance across SNF services, a more comprehensive assessment of a patient’s clinical needs and, potentially, more accurate payments that better align with costs. While we are supportive of moving toward RCS-1, we urge CMS to address the implementation issues discussed below, in collaboration with stakeholders, prior to finalizing the agency’s implementation plan for RCS-1. Such a plan and collaboration are needed before advancing to a standard notice of proposed rule-making process.

Ensure access to care for higher-acuity patients. Given the role played by hospital-based SNFs in treating higher-acuity patients, a top concern of the AHA is the ability of the RCS-1 to correctly estimate the resource needs of medically complex patients, which is critical for ensuring payment accuracy and, by extension, access to care. While the rule indicates that the RCS-1 would improve payment accuracy for cases with higher clinical acuity, it does so only at a high level and falls short of explaining how, in practice, patient access to care would be affected. Given the importance of ensuring access for this population, it would be helpful if CMS would discuss how beneficiaries’ access to care under the RCS-1 would be protected for each of the key elements of care: nursing, therapy, non-therapy ancillary, and other services.

Further, as the new model no longer relies on minutes of therapy to assign payment, through which some fluctuations in clinical need were readily captured, we are concerned that the rule fails to explain how “change of status” assessments will interact with payment

classifications as a patient's mid-stay needs evolve. As such, we urge CMS to comprehensively explain how it will ensure that beneficiaries grouped into one RCS-1 payment classification will not face difficulties being reassigned to another classification as their condition evolves during a 30-day episode. In addition, we ask CMS to provide far greater detail about the appeals process that will be available to help patients retroactively address short-comings 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.

Address concerns regarding the RCS-1 model's underlying data and changes in SNF patient population. We are concerned that the RCS-1 was built using outdated data – data from 1995 and a time study from 2006. This raises questions about the ability of the model to accurately and reliably project current costs given that substantial regulatory and marketplace interventions have occurred since that time that have materially changed the cost profile for SNF service delivery. As noted, the payment accuracy of this model is paramount to ensuring access to care for all patients requiring SNF services, especially for SNF patients with high-resource needs. As such, we encourage CMS to refresh the outdated RCS-1 data and re-run its models to ensure the reliability and accuracy of the payment system, and to ensure a mechanism to assess and adjust for changing trends in the future.

Similarly, others in the field have challenged CMS contractor Acumen's findings that the SNF patient mix has changed little from 2006 to the present. Indeed, these findings do not fit with reports from AHA members regarding ongoing and material shifts in post-acute care utilization patterns. For example, Medicare bundled payment programs and accountable care organizations have shifted many higher-acuity post-acute patients from high-intensity hospital-based post-acute care settings (inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs)) to less-intensive settings such as SNFs. In addition, CMS's tightening of IRF admission criteria in 2010 reduced the prevalence of joint replacement and other patients in IRFs. Further, the agency's more recent narrowing of 60% Rule-qualifying codes also tightened access to the IRF setting. Finally, the implementation of LTCH site-neutral payment in 2015 shifted LTCH admissions practices. We also note that heightened audits of these hospital-based settings contribute to a shift of patients from LTCHs and IRFs to less-intensive post-acute care settings. The dissonance between Acumen's assertion and apparent marketplace shifts warrants investigation by CMS to ensure that the RCS-1 model is accounting for, and able to accurately pay for, the true mix of patients currently treated in SNFs.

Change of status assessments. We are concerned about how the revised assessment schedule, which would require only five-day scheduled assessments, Significant Change in Status assessments, and discharge assessments would interact with the requirements of the current SNF quality reporting program (QRP) and the mandates of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. The various assessments likely would affect the overall minimum data set (MDS) schedule; specifically, it is unclear how the revised schedule would be integrated into the requirements that post-acute care providers collect and report standardized patient assessment data for all Medicare Part A

admissions and discharges beginning on Oct. 1, 2018, and how the MDS changes would affect the desired standardization of collected data across post-acute care provider types. We encourage CMS to provide additional context around exactly how these revised assessments would address the IMPACT Act domains.

Expand the implementation plan for the RCS-1. While substantial work has been conducted to develop the RCS-1 model, we are concerned that the model would not be “readily implementable,” as characterized in the rule. The RCS-1 information shared thus far by CMS is primarily a technical description of the model’s design – the rule offers little detail on how the payment system would be operationalized and overseen. CMS bears the responsibility to go beyond simply building the RCS-1 by also updating the multitude of inter-related rules and regulations through formal rule-making and sub-regulatory protocols. This full set of proposals must be tested and subjected to a transparent evaluation by and collaboration with stakeholders. Only then will stakeholders be able to meaningfully assess a mature RCS-1 implementation proposal.

In addition to providing a more comprehensive framework for implementation, we urge CMS to address the practical challenges providers will face in implementing a new payment system. For example, the RCS-1 model would be a dramatic shift away from payments being primarily determined by minutes of therapy. In practical terms, the new model would change therapy from being a revenue center to a cost center – which would represent a major paradigm shift for the SNF field and patients’ access to therapy. In addition, by calculating customized payments based on each patient’s unique blend of characteristics, the RCS-1 would yield more than 300,000 payment groups – far exceeding the number of payment units under the current SNF model and other payment systems. The challenges this complex new approach will present to providers warrants a comprehensive discussion in the rule. Of particular importance, when considering whether to admit a patient, SNFs need a manageable and reliable method for assessing patient needs and projecting payment to determine whether a patient is appropriate for a SNF admission – we are concerned that this has not been accomplished.

On a related note, we recognize that the RCS-1’s greater linkage of payments and patient characteristics aligns with the direction of other post-acute care payment reforms, such as the 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 shared how the proposed implementation of the RCS-1 fits with these payment reform initiatives. Thus, we also ask the agency to explain how the RCS-1 fits with these concurrent policy development and reform efforts.

Develop a comprehensive transition plan. We are concerned about potential transition difficulties for hospital-based SNFs and swing-bed hospitals if the new system is implemented, given the relatively small size of their operations and correspondingly 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. As a useful reference point, CMS's evaluation of the Bundled Payment for Care Improvement initiative for Models 2-4 found that many rural hospitals were less prepared to undertake major change. 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.

As such, we urge CMS to explain in detail how it would provide proactive education and assistance to patients, providers, payment contractors and IT vendors to help manage this transformative change. We also note that this transition would raise the need for ICD-10-CM coding due to the elevated importance of diagnostic information under the new model, and likely the need for some SNFs to, for the first time, hire certified coders.

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/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development