



June 26, 2017

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1679-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

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

Dear Sir/Madam:

I am writing on behalf of LeadingAge New York to provide our comments on the above-captioned proposed rule. LeadingAge NY represents nearly 500 not-for-profit and public providers of long term care and senior services throughout New York State, including nursing homes and continuing care retirement communities. Our national affiliate, LeadingAge, is an association of 6,000 not-for-profit organizations providing long term care services and supports throughout the United States.

Our comments on various aspects of the proposed rule follow.

***Wage Index Adjustment (Section III.D.)***

The Centers for Medicare & Medicaid Services (CMS) proposes to continue use of the hospital inpatient wage data in developing a wage index to be applied to SNF payments despite having statutory authority to do so. However, we believe that continued use of the hospital inpatient wage data fails to appropriately account for the significant variation in SNF paraprofessional wages across labor markets and the greater utilization of certified nurse aides and other paraprofessionals in the SNF setting than in the inpatient hospital setting. Underscoring this concern is recently enacted legislation in New York State that increases the state's minimum wage to \$15.00 per hour, which will add to this variation.

Accordingly, we recommend that CMS undertake the data collection necessary to establish a SNF wage index that is based on wage data from nursing homes. The collection and reporting of payroll data that are required for Payroll-Based Journal reports may facilitate the collection of SNF wage data that would make such an undertaking less resource intensive and provide easier access to valid wage data.

We also urge CMS to explore ways to base wage index updates on newer data. The current four-year lag means that providers (hospitals and home care agencies as well as SNFs) in states that have increased minimum wage will not have these major changes reflected in their wage index adjustments until four years after being required to increase wages.

### **Consolidated Billing (Section IV.B.)**

LeadingAge NY recommends that the chemotherapy agent Revlimid (a/k/a Lenalidomide) be added to the list of chemotherapy agents that are excluded from SNF consolidated billing requirements. This agent is labeled by the Celgene Corporation under National Drug Code # 59572-0410-28. We could not locate a HCPCS code for this agent other than J8999 (Prescription drug, oral, chemotherapeutic, Not Otherwise Specified). The Average Wholesale Price for a 28-day supply of Revlimid 10mg capsules exceeds \$18,000. We believe that this agent meets the statutory criteria of high cost and low probability in the SNF setting.

### **SNF Quality Reporting Program (QRP) (Section V.B)**

As part of the rule, CMS proposes to replace the current pressure ulcer quality measure, adopt four functional outcome measures and modify its hospital readmission measure. Our specific comments follow:

- The refined pressure ulcer quality measure should be properly risk-adjusted to ensure that it properly accounts for material risk factors related to the development or worsening of pressure ulcers and other skin integrity issues. Furthermore, such a change to the measure should be accompanied by sufficient public education and information if the refinement results in higher measure scores and greater variability in measure scores, as it is predicted to do.
- The proposed functional outcome quality measures would require modifications to the Minimum Data Set (MDS) and will be new to the SNF setting. As such, they will require additional data gathering, revised reporting methods and staff training and implementation costs. Prior to their use in the QRP, they should be properly field tested in the SNF setting and analyzed to ensure that reported values are valid and reliable. These modifications should be coordinated with other potential system changes such as the shift from the RUG-IV patient classification system to the RCS-1 system. SNFs will be financially challenged by the reduced 2018 market basket as well as VBP impact and potential QRP penalties, making additional costs that much more difficult to withstand.
- While we support the goal of increasing the number of SNFs with publicly reported data, we are concerned that the proposal to use two years of data in calculating the SNF Potentially Preventable 30-Day Post-Discharge Readmission Measure (SNFPPR) may cause confusion and consistency issues. Lengthening the time period and using fiscal years (when most SNFs report on a calendar period basis) is likely to reduce the credibility of the measure because it will increase the likelihood of inconsistencies in measurement methods across time periods. These revisions may cause confusion among consumers and make it more difficult for payers to use this key metric in value based payments. Furthermore, lengthening the time cycle of measurement will confound efforts to improve quality in real time. Given the increasing stakes tied to quality measures, SNFs must be able to validate calculations that CMS and states perform to arrive at various quality measures, and these revisions could impair facilities' ability to do so.
- We appreciate the acknowledgment that socioeconomic status (SES) can have a significant bearing on the outcomes of care. How the SES is applied is also critically important and must be well-considered prior to implementation. We are unclear as to which SES characteristics are

available in the Medicare eligibility files, and whether each characteristic has been evaluated independently and in combination with other characteristics to determine how to structure an appropriate adjustment. We are pleased to note that there is considerable work being done on this issue by the National Quality Forum, the HHS Office of the Assistant Secretary for Planning and Evaluation and the Institute of Medicine, but there is as of yet no current standardized approach or methodology to address SES in this context. Perhaps at the outset this research will identify one or more statistically significant SES factors that can be used to peer group SNF providers serving like numbers of such beneficiaries and compare performance across these peer groups of facilities.

- Failure to adequately and validly account for complex-care individuals may result in poorer quality scores for the new and revised QRP measures, thereby penalizing SNFs that provide care to medically-complex and socioeconomically disadvantaged residents, and threatening access to care.
- We recommend aligning these quality measures with those in use or planned for use in other major CMS initiatives including the Financial Alignment Initiative, the CMS Medicare value-based payment program, and Medicaid managed care initiatives under Section 1115 waiver authorities.
- We remain concerned that SNFs could be held responsible for the outcomes of care when other care coordination arrangements are in place (e.g., Accountable Care Organizations, Medicare bundled payments, Medicaid managed care arrangements for dual eligibles, etc.) for the beneficiary. We believe this same concern applies to the modifications made to the QRP measures in this rulemaking. The SNF may or may not be a direct party to these care arrangements, which incorporate payments for care coordination and quality/financial measure expectations. We believe that these overlapping initiatives could cause confusion among providers, skew results and incentives, and diffuse authority and accountability for the outcomes of care.
- Furthermore, there may be meaningful SES, clinical or other differences between beneficiaries in the Medicare FFS program (for whom these measures are reported) versus Medicare Advantage (MA) enrollees that could have a material bearing on comparisons between facilities with varying numbers of FFS and MA patients on one or more of these measures. This possibility should be investigated as part of the research being undertaken on SES factors.
- The additional QRP measures necessitate increased communication and collaboration between SNF and hospitals, other post-acute care providers, practitioners and other Medicare providers/suppliers. However, in stark contrast to its policies for hospitals and physician practices, the federal government has not provided SNFs and other post-acute care providers with financial support to deploy electronic medical records or engage in health information exchange. If SNFs and other post-acute care providers are expected to collaborate with other providers on transitions of care, to bring down the cost of post-acute care, to reduce avoidable hospital use and to conduct effective drug regimen reviews, they should have access to financial support for health information technology and health information exchange.
- We support the use of standardized data elements in the MDS that will facilitate consistency, efficiency in completion, and an informed approach to any modifications to the patient classification system utilized in the SNF PPS, provided that such standardization does not add to the cost burden of facilities.

## **SNF Value-Based Purchasing (VBP) Program (Section V.C.)**

### ***General Comments***

LeadingAge NY agrees that VBP – if properly designed and administered – can provide incentives to promote higher quality and more efficient health care for Medicare beneficiaries. However, we are concerned that a VBP program that relies exclusively on a hospital readmission measure to determine facility quality performance and value-based incentive payments ignores other important quality, structural and process elements of SNF service delivery.

In this regard, we continue to question whether Subsections (g) and (h) of Section 1888 of the Social Security Act actually require the VBP program to be based exclusively on performance on a hospital readmission measure, or whether other indicators such as quality measures, staffing levels and survey inspection performance could also be factored in to determine facility performance and incentive payments. Minimally, there should be a coordinated approach and shared goals/objectives between the VBP program, the SNF Quality Reporting Program and the Staffing Data Collection initiative.

We agree with CMS that the VBP program is likely to be more effective if it provides the opportunity for incentives, rather than simply for avoidance of penalties. We support using the Logistic Exchange Function as a way to achieve this objective. We believe that the most effective VBP program would distribute the entire payment amount that is held back. However, given the restrictions imposed by the authorizing statute, we strongly urge CMS to adopt 70 percent rather than 60 percent as the payback percentage. With FFY 2018 SNF rates reduced by \$500 million to help fund physician payments, significant MDS changes that will drive additional staffing and training costs and the potential revamping of the RUG methodology approaching, CMS should not make any additional funding reductions beyond those absolutely required. This would also make for a more effective VBP program with greater incentives for high performing facilities.

LeadingAge NY agrees that reducing hospital readmissions is important for quality of care and patient safety, and that preventing potentially avoidable hospitalizations is a policy imperative of the Triple Aim. While we believe that CMS should move to the SNFPPR as soon as practicable, proper refinement and testing of the measure is more important than expediency. Our other comments about the SNFPPR follow:

- While we understand that CMS is attempting to align hospitalization measures across its payment programs, we are concerned about the use of differing measures even within a service line. For example, the hospitalization measure utilized in the Nursing Home Five-Star Quality Rating differs from the SNFPPR. Such differences in measures are likely to cause confusion among consumers, providers and payers.
- The longer-term goal should be to align this measure with other relevant hospitalization measures planned for use. For example, states such as New York are working with CMS to develop VBP programs for their Medicaid programs under Section 1115 waiver authorities and as part of the Financial Alignment Initiative. With efforts underway to integrate care for dual eligible beneficiaries, efforts to reduce avoidable hospital use would be reinforced by ensuring

complementary approaches to hospitalization measures between the Medicare and Medicaid programs.

- While rounding to the nearest ten-thousandth of a point may be required to make it possible to rank all homes by avoiding tie scores, if this results in SNFs with nearly identical rates of hospital readmissions to earn back materially different VBP payment amounts, CMS should be open to revisiting and revising how these payments are awarded.
- SNFs do not have access to the data used to calculate the SNFPPR and, therefore, will not be able to validate their rates with the CMS outcome data. Of particular concern is the inability of SNF providers to access primary discharge diagnoses in order to validate the reason(s) for hospital admission.
- As in our comments relative to the QRP, we agree with the recommendation to reflect social risk factors in risk adjustment. However, we are unclear as to which social risk characteristics are available in the Medicare eligibility files, and whether each characteristic has been evaluated independently and in combination with other characteristics to determine how to structure an appropriate adjustment.

We support the CMS proposal to include an Extraordinary Circumstances Exception Policy under the SNF VBP program to address SNFs that are affected by natural disasters or other circumstances beyond their control.

### **Request for Information on CMS Flexibilities and Efficiencies (Section VIII.)**

LeadingAge NY members have long been at the forefront of delivering person-centered care and, as such, we have supported efforts that fully promote and sustain environments within which residents make decisions and have control over their lives. However, we remain concerned that certain elements of the final rule, *Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities* [81 Fed. Reg. 68688; Oct. 4, 2106], created requirements that are unrealistic, ambiguous and/or contrary to sound standards of practice, and entail potentially significant costs without provision for payment.

#### ***Discharge Notices***

LeadingAge NY supports CMS' re-evaluation of its requirement for nursing homes to send discharge notices to the state Long Term Care Ombudsman, which will create a paperwork burden for both providers and ombudsmen. The requirement for notification to the state Long Term Care Ombudsman should be limited to cases of involuntary transfers or discharges.

#### ***Facility-Wide Assessment***

Nursing homes typically engage in multiple processes to validate that the needs of residents are being met. Staffing, education, equipment and care-related products are continuously evaluated to assure they are appropriate in number and scope and sufficient in quality to meet the needs of residents. We are very concerned about the surveyor use of this newly created, undefined and stand-alone regulatory requirement and the potential for surveyors to create a linkage between the facility-wide assessment and any other non-compliant area. It is impossible to evaluate this requirement in the

absence of any interpretive guidelines and, as such, we would propose that it be eliminated until CMS is prepared to provide far greater clarity on what would constitute facility compliance in this area.

### ***Quality Assurance Performance Improvement (QAPI)***

The regulation provides that surveyors will have access to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events. We are concerned that this requirement would confer broad and unlimited access to QAPI documentation to the survey team. This creates the potential for the facility's own QAPI activities to be used to identify or possibly support findings of non-compliance. Under longstanding federal law, documents are privileged from disclosure if they are generated by a facility's quality assessment and assurance (QAA) committee and used in the facility's quality assurance processes. The rationale for this privilege is that QAA committees are key internal mechanisms that allow nursing homes opportunities to address quality concerns in a confidential manner that can help them sustain a culture of quality improvement. We are concerned that this aspect of the regulation may have a chilling effect on advancing QAPI efforts, and should be reconsidered.

### ***Timing of Implementation of These Requirements***

The final *Reform of Requirements for Long-Term Care Facilities* rule made major changes to the nursing home requirements affecting multiple areas of facility operations, at a time of major shifts in federal and state payment policies, quality expectations and provider-payer relationships. These changes are necessitating significant revisions to facility policies and procedures; developing and conducting training; hiring or otherwise acquiring needed expertise; assessing preparedness; and planning for all associated compliance costs.

Given the significant changes underway and the sheer magnitude of the proposed changes contemplated in this rule, we strongly recommend revisiting the requirements noted above, as well as delaying the implementation of phases two and three of the regulatory revisions. The current timeframes create added concerns about compliance cost, training and coordination challenges for facilities. Regulators will also need time to understand the proposed changes, develop interpretive guidance, modify survey processes, train surveyors and otherwise be in a position to objectively and consistently evaluate facility compliance.

For many of these regulatory revisions, CMS will need to develop sub-regulatory requirements including interpretive guidelines to provide much greater detail and guidance on the regulatory revisions. LeadingAge NY strongly recommends that provider organizations and association representatives be involved in the development of these specific requirements and guidelines to ensure they are consistent with sound practice, pragmatic in approach, sufficiently flexible, cost-effective and representative of the current realities of providing nursing home care to an increasingly complex and diverse resident population.

### **Conclusion**

Thank you for the opportunity to provide input on the proposed rule. If you have any questions on our comments, please contact me at (518) 867-8383 or [dheim@leadingageny.org](mailto:dheim@leadingageny.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Daniel J. Heim", followed by a horizontal line extending to the right.

Daniel J. Heim  
Executive Vice President