June 26, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1969-P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: 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 (CMS-1696-P)

Dear Ms. Verma:

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 Skilled Nursing Facilities (SNFs) 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.

LeadingAge NY supports the Centers for Medicare and Medicaid Services (CMS) goal of creating a simple, streamlined Medicare Part A SNF Prospective Payment System (PPS) rate methodology and ensuring that resident care decisions appropriately reflect each beneficiary's actual care needs. We agree it is appropriate to derive payment from objective resident clinical and functional characteristics to the extent possible, and in a way that ensures that the resulting prospective payments are predictive of differences in provider costs across the payment categories.

LeadingAge NY also appreciates that the revisions reflected in the Patient-Driven Payment Model (PDPM) reflect CMS consideration of the comments that were submitted in response to the May 2017 Advance Notice of Proposed Rulemaking that introduced the Resident Classification System Version I (RCS-1), and that CMS and Acumen have utilized more current data in developing and refining the model and calculating provider impact estimates. While optimistic that PDPM will ultimately represent an improvement for most SNF residents and providers, we are certain that the magnitude of the change will require extensive reorientation, training and systems redesign for providers, vendors, Medicare Administrative Contractors (MACs) and CMS at the same time as several other major SNF programmatic initiatives are being implemented.

In the short-term, we are greatly concerned about the major shifts in payment that are estimated to occur in transitioning from the current system to PDPM. As discussed in our comments, it is unclear to what degree these estimated impacts are the result of new features of the system; the lack of

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behavioral assumptions related to changes in SNF care delivery; and/or issues with the data underlying the impact analyses. LeadingAge NY urges CMS to conduct additional analyses and make further refinements to the system (including recommendations related to a transition methodology or outlier policies) to address these concerns.

LeadingAge NY endorses the separately submitted comments of our national affiliate, LeadingAge, and stresses the following areas of general concern that should be addressed and/or clarified as CMS works to finalize the proposal:

1. SNF wage index;
2. Impact modeling and data sources;
3. Determination and coding of primary diagnosis;
4. Resident assessment schedule changes;
5. Transition issues;
6. SNF Quality Reporting Program;
7. SNF Value-Based Purchasing;
8. Education and training needs;
9. Budget neutrality;
10. Potential impacts on other federal initiatives; and
11. Potential impact on states.

SNF Wage Index

Since direct care labor inputs represent a large proportion of SNF input costs, the wage index has a material bearing on the level of Medicare PPS payments received by a SNF, and whether those payments are predictive of the costs which must be incurred to provide SNF care. CMS has utilized the hospital wage index to adjust SNF payments to account for differences in area wage levels since the inception of the SNF PPS.

CMS received legislative authority in 2000 [the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106-554] to establish a SNF-specific geographic reclassification procedure, provided the agency collects the data needed to establish a SNF wage index. However, CMS has declined to develop a SNF wage index on the basis that the existing SNF wage data are unreliable and that considerable resources would need to be expended by CMS and the MACs.

Under PDPM, CMS proposes to continue to use the hospital inpatient wage data to adjust SNF payments for differences in area wage levels. We believe that continued use of the hospital inpatient wage data fails to appropriately account for 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 our concern is enacted state legislation that is gradually increasing New York's minimum wage to $15.00 per hour, which will add to this variation.

In proposing the biggest change to the SNF PPS methodology since its inception, CMS should take the opportunity to rationalize all parts of the rate setting methodology, including implementation of a SNF wage index. The wage index utilized in the SNF PPS has a major bearing on achieving the goal of

creating a model that compensates SNFs accurately based on the resources necessary in caring for SNF beneficiaries.

Accordingly, we strongly recommend that CMS undertake the data collection necessary to establish a SNF wage index that is based on wage data from nursing homes. The framework used to collect payroll data that are required under the Payroll-Based Journal initiative may facilitate the collection of SNF wage data that would make such an undertaking less resource intensive and provide easier access to standardized and verifiable wage data. Development of a SNF wage index would also make it possible to implement a geographic reclassification procedure that is specific to SNFs to better reflect actual labor market conditions and further improve Medicare payment accuracy.

LeadingAge NY further urges CMS to explore ways to base wage index updates on more recent data. The current four-year lag means that providers (hospitals, home care agencies and hospices, 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.

Impact Modeling and Data Sources

LeadingAge NY commends CMS for using updated data to complete additional analyses and to model impact estimates for the PDPM system. However, we are concerned that the impact estimates suggest that New York State providers would face an overall reduction in SNF Part A payments. Based on the CMS/Acumen analysis (and assuming the same Medicare residents with the same lengths of stay and receiving the same services in each SNF as in 2017), 52 percent of homes in New York would see a total revenue decrease if reimbursement for these same residents were provided using the new payment model. The statewide estimated aggregate funding decrease for New York State is $87.9 million based on the 506 homes with estimates.

While estimates for a majority of our individual members are positive, we are specifically concerned about: (1) large percentage and dollar negative impacts estimated for certain of our member SNFs; (2) the approximately 100 New York SNFs (over 15 percent of the total SNFs in the state) for which CMS provided RCS-1 estimates but for which no PDPM impact estimates are provided; and (3) the large magnitude of change between the RCS-1 impact estimates and the PDPM estimates. These circumstances raise questions concerning the reliability, accuracy and completeness of the data used to develop not only the impact estimates but to formulate the various features of the PDPM system. On this basis, we also question whether there is sufficient understanding about how the various changes in the methodology are contributing to the estimated impacts at the provider characteristic stratum and facility-specific level.

With regard to the reliability and accuracy of the data used for modeling, we would point to the example of the admission performance assessment in Section GG of the Minimum Data Set (MDS), which is being used to develop the nursing Activities of Daily Living (ADL) score in lieu of the late-loss ADLs derived from Section G that are utilized in the RUG-IV case-mix classification system. Section GG was initiated in Oct. 2016 and underwent changes in Oct. 2017. Given the recency of this section and the revisions to it, as well as continued use of Section G and the lack of connection of Section GG to payment, analyses of ADL scores and impact estimates based on this information may not be reliable.

We urge CMS to continue to collect and analyze data during the pre- and post-implementation periods from Section GG and other data sources that would have the most material bearing on resident classification and the case-mix weights under the PDPM. These data should be used to inform the final version of the PDPM slated for implementation. Specifically, CMS should monitor and adjust case-mix qualifiers and weights as needed in advance of and following implementation.

In addition to concerns about the data underlying the system design, we are also concerned about the magnitude of the estimated changes in payment for certain resident characteristics, most notably HIV/AIDS for which a 40.5 percent reduction in SNF PPS revenues is estimated. While HIV/AIDS residents comprised 0.3 percent of the resident stays in the impact analysis, medical and clinical staff serving patients with HIV/AIDS have indicated to us that a significant growth is expected in this population over the next several years given improved pharmacology and increased life expectancy, and that the cost of medication therapy is significant and increasing. We urge CMS to re-examine the level of reimbursement that would result from PDPM for patients with HIV/AIDS.

Determination and Coding of Primary Diagnosis

Under the proposed rule, residents would be classified into clinical categories in PDPM for purposes of therapy services using item I8000 of the MDS, which reports the ICD-10-CM code representing the primary reason for the resident's SNF stay. Additionally, residents who received a surgical procedure during their hospital stay would have an ICD-10-PCS code entered in the second line of item I8000 to ensure the appropriate clinical category.

CMS should consider alternatives to relying on ICD-10 CM codes for this critically important data item in the PDPM. SNF familiarity with the ICD-10 CM coding system, and particularly the ICD-10 PCS codes, is quite limited. SNFs would need to hire new staff conversant in this coding, and would incur significant education and training expenses as a result. The alternative of using MDS item I0020 seems problematic as well. While it is pre-populated with a list of primary diagnoses, those diagnoses may not correspond with the proposed PDPM clinical categories. We propose in the alternative that Section 1 of the MDS be augmented with a set of clear questions that would gather the responses necessary to categorize each resident into one of the four collapsed clinical categories.

We have identified other issues related to determination of primary diagnosis in PDPM:

- SNF clinicians and coders may have difficulty in determining a resident's primary diagnosis for this purpose in cases when clinical judgement could result in multiple possibilities. In this regard, the selection of the data source(s) to be used for principal diagnosis together with clear instructions, education and training will be key.
- Hospitals and physicians may not timely provide the SNF with complete information and documentation needed to assign a primary diagnosis in the initial MDS assessment, or the information may change from what is initially provided to the SNF at discharge. This could result in misalignment of payments with care costs, and create unwarranted audit exposure for the SNF.
- A SNF should not be penalized if the discharging hospital revises the resident's primary diagnosis subsequent to submission of the SNF's initial MDS assessment. A procedure should be established to allow for correction of the MDS in these situations.

- Given that there will be a new approach to coding and utilizing the resident's primary diagnosis with which SNFs will be unfamiliar, there will be a significant potential for errors in coding, particularly in the earliest stages of implementation. Procedures will be needed during some reasonable transition period to allow for MDS corrections for a longer time period than is currently permitted.

Resident Assessment Schedule Changes

While we support the intent to reduce administrative burden by reducing the number of required assessments, we do have two concerns. We are also seeking clarification on the criteria for filing Interim Payment Assessments (IPAs).

Under the proposed PDPM methodology, the 5-day SNF PPS scheduled assessment would be used to classify residents for their entire Part A stay (unless an IPA is filed). If a SNF does not receive complete and accurate information and documentation from the discharging hospital, the assessment is not likely to be accurate. Similarly, if the hospital billing system is such that ICD-10 codes are finalized after discharge, it may be challenging for SNF staff to complete the assessment on time. Preliminary coding that is subsequently changed by the discharging hospital may make the SNF susceptible to audit or review. CMS should consider requiring hospitals to provide SNFs with diagnostic and other clinical information within a specified timeframe of discharge. This is especially important since few hospitals and SNFs are connected through electronic medical records. CMS should also provide flexibility to allow SNFs to correct information on both MDS and claim forms during the first year of implementation.

The second concern is related to the IPA. While it may appear to be a reduction in administrative burden, we are concerned that the need for constant monitoring for "first tier" changes in each of the case-mix adjusted components will be no less burdensome than the current assessment schedule. The need to track the many variables may result in missed IPAs, which could result not only in misaligned payments, but also to default rates and non-payments in those cases where a change is identified after the fact. We believe these payment penalties are too severe, especially during implementation.

The rule would require providers to complete an IPA in cases when the first tier classification criteria for any of the case-mix adjusted components changes in a way that results in a payment change. We are seeking clarification on what constitutes a "first tier" change in the nursing component. We would also like to know whether the default rate and provider liability rules would apply to a provider that fails to complete an IPA that would have resulted in a payment increase.

Transition Issues

The PDPM proposal represents a significant shift not only in payment but in methodology that would drive large changes in provider, vendor and MAC/CMS systems and practices. It is based on analysis of data that may be changing (e.g., better reporting on relatively new section GG), on modeling that assumes the same resident population (e.g., does not consider increased medical complexity driven by shorter hospital stays) and that is blind to potential changes in provider behavior (e.g., potential increases in group and concurrent therapy). Providers and CMS must recognize that along with the opportunity for costs to be more appropriately reflected in reimbursement, the untried methodology

also carries a potential risk for mis-pricing. For PDPM to succeed as a payment methodology, CMS must monitor its predictive performance and recalibrate if operational issues reveal payment inadequacies, residents with specific characteristics encounter difficulty finding placement, or other systemic weaknesses are identified. This should include initial and ongoing analysis with the promise of targeted recalibration as necessary to ensure the component case-mix weights appropriately and accurately predict costs based on patient characteristics.

Successful implementation requires CMS to provide information, implementation resources as well as training, education and tools for various stakeholders. If ICD-10 is used as a primary mode for classifying residents into payment categories, CMS should provide coding training and educational resources to clinicians, therapists as well as administrative staff. Education on the new methodology should also target Medicare Advantage plans, vendors, hospitals, and consumers. Although the payment incentives of the methodology seem to line up with desired outcomes, CMS should be aware of unintended consequences and be prepared to address them. Tracking changes in therapy use should include not only scrutiny of therapy volume from discharge assessment and examination of group/concurrent therapy use but also analysis of therapy-related outcome measures.

Providers must feel confident that CMS will address problems promptly and that it will be willing to assist while PDPM is being put into place. During the implementation period, which could last six months or up to a year based on how smoothly the expected roll-out proceeds, CMS should provide increased flexibility when enforcing implementation-related rules. This includes leniency for good cause delays in identifying and reporting information on MDS and claim forms and more reliance on informational rather than punitive audits where evidence suggests inadvertent error as the cause.

SNF Quality Reporting Program (QRP)

The proposed rule includes a recommendation that for any SNF that does not satisfy the FY 2019 SNF QRP reporting requirements, CMS would apply the 2 percentage point reduction to the SNF market basket percentage change after the effect of any forecast error adjustment and the multifactor productivity (MFP) adjustment. For FY 2019, this would result in a 0.1 percentage reduction in such a facility's payment rate.

Given the impending changes in SNF PPS rates and the increased compliance costs we believe will be necessary in connection with initial PDPM implementation, LeadingAge NY recommends alternatively that the 2 percent reduction be taken against the 2.4 percent market basket adjustment required by the Balanced Budget Act of 2018 (BBA 2018) rather than the 1.9 percent market basket adjustment net of the MFP adjustment. This would ensure that such facilities not receive a net reduction in rates.

SNF Value-Based Purchasing (VBP)

We offer the following comments related to the SNF VBP program:

- Low-volume SNF providers should be excluded from the VBP and the associated reduction in payments, as they have no realistic opportunity to earn back any portion of the reduction given their low volume of Medicare residents.

- 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. Research efforts should be coordinated with states that may already be doing work in this area such as New York.
- CMS should announce when it intends to implement the SNF Potentially Preventable 30-Day Post-Discharge Readmission (SNFPPR) measure, and should consider standardizing/ consolidating various SNF hospitalization measures used in Medicare to allow providers to focus their quality improvement efforts. Particularly when combined with state initiatives that may have similar measures that are based on different data, the multitude of hospitalization measures becomes confusing for consumers, and provider improvement efforts are convoluted and diluted.

Education and Training Needs

Case-mix adjustment under PDPM would be much more dependent on diagnoses and clinical conditions and would base the payment for the entire SNF stay on information provided on the 5-day MDS assessment (with a requirement that an IPA be filed if a resident's change in condition met established criteria). This will require training for clinical personnel and additional coding staff. Clinical staff will be required to recognize and communicate more clinical information in a shorter timeframe while coders will be required to ensure that accurate information with significant payment implications is coded and entered correctly. If PDPM relies on ICD-10 codes to designate the primary diagnosis, it will require the type of coding expertise that is not common in many nursing homes. This will be especially critical expertise if reimbursement for the entire stay is predicated on the initial 5-day assessment, as is proposed.

The change in methodology with its shift away from a focus on therapy should also be the subject of a CMS education campaign for Medicare recipients. There will be likely continuing expectations for therapy that PDPM may not meet. CMS should consider what type of educational activities will be necessary for Medicare recipients and their advocates to ensure that resident expectations are in line with CMS efforts.

Given the magnitude of the methodological change, the need for fundamental updates to provider and vendor software systems, the requirement for staff training and the potential need for managed care contact revisions, CMS should provide updates to the MDS Resident Assessment Manual (RAI) along with technical specification for software vendors as quickly as possible. Providers should have at least a year from the issuance of the final rule to fully understand the methodology, to make requisite staffing adjustments and update contracts, to adjust software systems and to provide necessary training to accurately implement a new methodology. This is especially true at a time when both CMS and states are in the process of implementing various new quality and value-based payment initiatives, including major changes to the MDS and implementation of the recent and extensive revisions to the SNF RoPs and the new survey process.

Budget Neutrality

Given the increased costs of staff training, software redesign and other administrative costs to implement a new payment system, CMS should consider providing additional funding for initial implementation. SNFs continue to be impacted by the two percent MFP reduction, face a FFY 2019 market basket increase lower than the market would otherwise dictate due to BBA 2018, and are subject to a potential two percent reduction by the SNF QRP. Additionally, the SNF VBP program will reduce aggregate payments to providers by reducing Part A payments by two percent yet allowing providers to "earn back" only 60 percent of the aggregate reduction.

SNFs also continue to implement the revised Requirements of Participation (ROPs) and will need to engage in training related to ongoing MDS changes. Administrative costs related to increased Medicare managed care penetration as well as state managed care and/or quality initiatives coupled with inadequate Medicaid reimbursement place further financial stress on SNFs.

After initial implementation, CMS should analyze whether the rates are sufficient and base budget neutrality decisions on the outcome of the analysis.

Potential Impacts on Other Federal Initiatives

The major shift in emphasis of the PDPM system from service provision to resident characteristics could have significant effects on other federal reporting and payment initiatives, particularly as SNFs respond to the new payment incentives. In conjunction with a proposed rulemaking and post-implementation, CMS should assess the impact of PDPM and make any needed revisions to the following programs and any other federal initiatives that may be affected:

- The quality measures included in the CMS SNF 5-Star rating system, particularly for short-term residents who may evidence more clinical conditions and functional limitations in response to PDPM;
- The 5-star staffing ratings, which are case-mix neutralized and will be affected by changes in resident scoring under PDPM;
- The measures reported under the SNF QRP;
- The impact of changes in SNF therapy reimbursement and resident clinical conditions on the Bundled Payments for Care Improvement and Comprehensive Care for Joint Replacement initiatives;
- Facility performance over time on the SNFPPR measure which will be utilized in the SNF VBP initiative;
- Setting capitation payments for Medicare Advantage and managed care programs for dual eligibles which incorporate the SNF benefit; and
- Ongoing implementation of the new RoPs and accompanying survey process.

Potential Impact on States

The proposed rule requests public comment on other potential issues CMS should consider in implementing revisions to the current SNF PPS, such as potential effects on state Medicaid programs. New York State relies on MDS assessment data received from CMS to categorize residents

into RUG-III categories to calculate a case-mix adjustment used in Medicaid rates. While the changes to the incentives in the resident classification system are significant, we do not believe they would have a major bearing on Medicaid rates since long-stay Medicaid residents are likely to have predominantly clinical and functional needs and are typically less likely to be classified into a rehabilitation RUG.

Having said that, we urge CMS to work with New York and other states to ensure that any MDS data that they currently rely on for Medicaid rate setting remains available to them with the change in methodology. Furthermore, it may be helpful for CMS to develop and offer a truncated PDPM resident classification system that states could elect to use to case-mix adjust Medicaid rates of payment.

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.

Sincerely,

Daniel J. Heim
Executive Vice President