June 18, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1718-P
P.O. Box 8016
Baltimore, MD 21244–8016

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2020 (CMS-1718-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 over 400 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 endorses the separately submitted comments of LeadingAge.

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 the Patient Driven Payment Model (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

13 British American Blvd. Suite 2, Latham, New York 12110-1431
p 518.867.8383 | f 518.867.8384 | www.leadingageny.org

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 advancing 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.

Finally, we question whether CMS's proposal to address Medicare wage index disparities for hospitals [as reflected in the Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule] will have any effect on the wage indices assigned to SNFs. We would note that increasing Medicare payments to rural hospitals by increasing their wage indices could adversely affect rural SNFs competing in the same labor market if SNFs did not receive a comparable wage index adjustment. In turn, any corresponding reductions to the wage indices assigned to SNFs in high compensation cost areas would create labor affordability issues for those facilities.

Consolidated Billing

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. Lenalidomide is a cancer drug and is also known by its brand name, Revlimid. It is a treatment for myeloma and blood disorders called myelodysplastic syndromes. This agent is labeled by the Celgene Corporation under National Drug Code (NDC) # 59572-0405, and is identified solely by an NDC with no specific HCPCS code assigned. The Average Wholesale Price for a 28-day supply of Revlimid 10mg capsules exceeds $21,000. We believe that this agent meets the statutory criteria of high cost and low probability in the SNF setting.

We further recommend that CMS conduct a broad review of new chemotherapy drugs and their costs to determine whether any additions should be made to the exclusion list, as new drugs are being added regularly and do not always have their own HCPCS code.

Payment for Certain Swing Bed Services

As noted in the proposed rule, SNF-level services furnished by non-critical access hospital (CAH) rural hospitals are paid under the SNF PPS, effective with cost reporting periods beginning on or after July 1, 2002. However, Medicare Part A pays for SNF-level services furnished by CAHs under a swing-bed agreement at 101 percent of reasonable cost, pursuant to statute [i.e., the Balanced Budget Act (BBA) of 1997]. This creates a major discrepancy in payment between a CAH and any area SNFs (which are paid under the SNF PPS) for comparable services, placing these rural SNFs at a serious financial and competitive disadvantage. We recommend that CMS seek statutory authority to either pay for CAH swing bed services under the SNF PPS, or to make appropriate adjustments to Medicare payments for SNFs located in the same geographic areas as CAH swing bed providers.

Revised Group Therapy Definition

LeadingAge NY supports CMS's proposal to define group therapy in the SNF Part A setting as a qualified rehabilitation therapist or therapy assistant treating two to six patients at the same time who are performing the same or similar activities. We agree that this definition would offer therapists far more clinical flexibility than the current fixed definition of four patients when determining the appropriate number for a group, without limiting the therapist's ability to manage the group or each patient's ability to interact effectively and benefit clinically and socially from group therapy. Furthermore, this standard aligns with the Inpatient Rehabilitation Facility setting standard for group therapy.

Provider, Vendor and Contractor Readiness for PDPM

We appreciate the PDPM resources CMS has made available to providers, vendors and contractors. While most SNF providers have strong relationships with their discharging hospitals, the structure of PDPM makes it imperative that SNFs receive current and accurate information from hospitals. CMS should consider providing some PDPM educational materials aimed at hospital providers. A successful transition will require providers as well as software vendors and Medicare Administrative Contractors (MACs) to have effectively updated or created the necessary systems to facilitate new billing conventions and to be able to address any problems that may arise. We urge CMS to monitor vendor readiness and ensure MACs have the capacity to help address billing issues that may arise during the transition to the new methodology without delay.

SNF Quality Reporting Program (QRP)

LeadingAge NY is broadly concerned about proposals to implement substantial additions and revisions to the MDS within only one year of implementation of the PDPM methodology. Under PDPM, SNFs will be under considerable time pressure to complete the 5-day SNF PPS scheduled assessment, which will generally determine Medicare reimbursement for the beneficiary's entire Part A stay. We believe that CMS should consider staging any added SNF QRP requirements in a way that provides SNFs with more time to adapt to major changes in the payment methodology, as well as the continued phase-in of the revised Requirements of Participation and survey process. Following are our specific comments on various aspects of the SNF QRP:

1. Proposed Transfer of Health Information Measures

We agree that incomplete or missing health information increases safety risks to patients/residents, and that inadequate communication and coordination across health care settings contributes to patient complications, hospital readmissions, emergency department visits, and medication errors. Transfer of medication information to patients on discharge can promote their active participation in medication management. Transfers of medication lists between providers are needed for medication reconciliation interventions and to address these risks, and the proposed rulemaking notes that the risks of adverse drug events are minimized when medications are reviewed by a pharmacist using electronic medical records (EMRs).

While the rule acknowledges that such information may be transferred verbally, on paper or electronically, CMS has not provided funding to nursing facilities to facilitate deployment of EMRs and health information exchange as it has for acute care providers and physician practices in spite of the potentially increased effectiveness of electronic communication. For this and other reasons, meaningful use incentives should be extended to SNFs and other post-acute care providers. Furthermore, SNFs receive a majority of their admissions from hospitals and are dependent on receiving timely, complete and accurate information and documentation from the discharging hospital. This is even more important when the patient requires only a short stay in the SNF. 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 relatively few hospitals and SNFs are connected through EMRs.

2. Proposed Update to the Discharge to Community – PAC SNF QRP Measure

We support the proposed revisions to the specifications for the Discharge to Community – PAC SNF QRP measure to exclude baseline nursing facility residents from the measure. SNFs in particular provide services to two populations – individuals requiring post-acute care services who are often discharged back to the community or another type of congregate facility within a relatively short time; and individuals who need facility-based long-term care services due to chronic illnesses and/or functional limitations for whom community discharge is most often not a viable goal. Refining this measure to focus on the post-acute care population will enhance its validity and reinforce the overall intent of the SNF QRP.

3. SNF Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements under Consideration for Future Years: Request for Information

LeadingAge NY appreciates the opportunity to comment on these proposed measures. It is not entirely clear to us which measures were considered in each domain and how these particular measures were selected. We support efforts to utilize existing MDS elements to facilitate capture of data utilized in the proposed Standardized Patient Assessment Data Elements (SPADEs) to minimize the added burden of information gathering for both facilities and residents.

For those SPADEs requiring collection of additional data elements and sub-elements (e.g., special services, treatments, and interventions), CMS should estimate the additional time that will be required to complete MDS assessments incorporating these elements and pay for the added nursing and other staff time in SNF PPS rates of payment. Selection of measures should be influenced by, and consistent

with, implementation of the new Requirements of Participation and directly relevant to resident care planning activities.

- **Healthcare-Associated Infections in Skilled Nursing Facility**

We believe that the proposed measure Healthcare-Associated Infections in Skilled Nursing Facility should distinguish between infections acquired in the SNF versus a hospital or in the community. The presence of a healthcare-associated infection is not necessarily indicative of the quality of care provided by the SNF and therefore, the measure would not be serving its intended purpose of measuring the quality of SNF care if such a distinction is not made.

- **Impairment Data – Hearing and Vision**

LeadingAge NY agrees that accurate diagnosis and management of hearing and vision impairment would likely improve patient safety, patient outcomes, and care transitions, but we are concerned by the statement, "Accurate assessment of hearing and vision impairment would be expected to lead to appropriate treatment, accommodations, including the provision of auxiliary aids and services during the stay, and ensure that patients and residents continue to have their vision and hearing needs met when they leave the facility."

We agree that SNFs should screen for these impairment and provide some accommodations, resources, and referrals for treatment after discharge, but do not agree that a SNF should be required to provide costly and time consuming treatment for these impairments for a short-stay SNF patient. The final rule should clarify that a SNF is not responsible for pursuing treatments and services beyond the scope of care and services normally provided by the SNF and reflected in the SNF PPS rates of payment.

- **Social Determinants of Health (SDOH): Social Isolation**

LeadingAge NY has consistently supported the addition of SDOH to the SPADEs, recognizing how these elements impact the care of Medicare beneficiaries. Gathering these data will inform our understanding of resident and patient complexity and risk factors that may affect utilization of care, care outcomes and associated costs, and facilitate better alignment of payments with the added challenges posed by SDOHs.

Relative to short-term stays covered by Medicare, we recommend adding a qualifier to the proposed SDOH measure for social isolation to ensure the patient's response reflects his/her home environment. The patient's experience of hospital and post-acute care is unlikely to be representative of his/her normal daily life, the latter of which should be the focus of post-discharge resources and referrals.

4. Proposed Data Reporting on Residents for the SNF Quality Reporting Program Beginning with the FY 2022 SNF QRP

While LeadingAge NY understands the rationale for seeking data for all SNF residents regardless of their payer, we believe this will add substantially to the reporting burden associated with the SNF QRP since facilities will be expected to respond to additional questions on virtually all MDS assessments performed for a much larger number of residents to meet QRP requirements. Facilities that are located in states such as New York that require all Medicaid NF beds to be dually certified for Medicare and/or

that use the MDS 3.0 to calculate acuity adjusted payment rates for Medicaid NF services (which may require submission of additional state-only assessments) would be most adversely affected by this requirement. If this proposal is adopted, it should be implemented at a point in time after the FY 2022 SNF QRP to ensure added transition time following incorporation of the SPADEs and other revisions.

Furthermore, several of the selected quality measures are much more relevant to the provision of the episodic, short-term care typically associated with Medicare, and are either not particularly relevant to or unrepresentative of, the long term care population. Careful consideration should be given as to how this information will be publicly displayed and appropriately caveated to ensure it properly reflects the distinctions between short-term post-acute and long term care.

SNF Value-Based Purchasing (VBP)

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

1. SNFPPR Update – Change of Measure Name

LeadingAge NY has previously commented that the potentially preventable hospital readmission measures used in the SNF VBP program and the SNF QRP are confusing to providers and may be even more confusing to consumers. Accordingly, we support the proposal to better distinguish the SNF VBP measure from the SNF QRP measure by changing the name of the Skilled Nursing Facility 30-Day Potentially Preventable Readmission to the Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge. CMS should announce when it intends to implement this measure as soon as possible, with sufficient lead time for providers and other stakeholders.

2. Public Reporting on SNF Performance Scores, Achievement and Improvement Scores, and Ranking

LeadingAge NY supports CMS's proposal to suppress SNF information displayed on the *Nursing Home Compare* website in situations when SNFs have fewer than 25 eligible stays during the SNF VBP baseline or performance periods. We agree with CMS that this policy revision will balance the interests of publishing as much information as possible about SNF VBP performance for users of *Nursing Home Compare* and ensuring that the published information is representative, reliable and meaningful relative to a SNF's performance under the program. The website should explain why scores are suppressed based on the revised rules so that consumers can accurately and fairly interpret the available data.

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