

June 18, 2019

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

CMS—1718—P: 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 FY 2020

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 750 hospital-based skilled-nursing facilities (SNFs), and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2020 proposed rule on the SNF prospective payment system (PPS).

In addition to other changes, the proposed rule would make refinements to the major SNF PPS redesign that was finalized in last year's rulemaking and will take effect Oct. 1. **The AHA supports the new payment model, known as the patient-driven payment model (PDPM), in that it would increase overall payment accuracy for SNF patients, especially for the medically complex patients treated at disproportionately high rates by hospital-based providers.** In addition, we are pleased to have been involved in two of the CMS technical expert panels (TEPs) hosted to collect input during its extensive research and development period.

Our detailed comments pertain to the proposed redefinition of group therapy, as well as proposed changes to quality reporting and patient assessment protocols for SNFs.



PROPOSED CHANGE TO GROUP THERAPY DEFINITION

The AHA supports the proposed new group therapy definition for SNFs, which mirrors the less-restrictive definition applied by inpatient rehabilitation facilities (IRFs): two to six patients performing the same or similar therapy activities under the supervision of a therapist or therapy assistant. Currently, CMS defines SNF group therapy as the practice of one therapist or therapy assistant treating exactly four patients at the same time while the patients are performing either the same or similar activities. Following its monitoring of therapy utilization patterns in SNFs and other settings, CMS found that therapists in SNFs have the clinical judgment to determine whether groups of different sizes would benefit their patients. We also note CMS's mention in the rule that individual therapy is the preferred SNF therapy mode, with group therapy primarily effective as a supplement to individual therapy.

QUALITY REPORTING-RELATED PROPOSALS

SNF QUALITY REPORTING PROGRAM (SNF QRP)

The Affordable Care Act mandated that reporting of quality measures for SNFs begin no later than FY 2014. Failure to comply with SNF QRP requirements results in a 2.0 percentage point reduction to the SNF's annual market-basket update. For FY 2020, CMS requires SNFs to report 11 quality measures.

In the rule, CMS proposes to add two measures to the FY 2022 SNF QRP. In addition, CMS would require SNFs to collect certain standardized patient assessment data beginning with SNF admissions on or after Oct. 1, 2020 to meet additional Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requirements.

While the AHA appreciates that the proposed measures are intended to address important aspects of care transitions and have undergone significant improvements over the past few years, we continue to encourage CMS to adopt only measures that have received endorsement by the National Quality Forum (NQF). Furthermore, we urge CMS to reconsider its proposal to adopt the dozens of standardized patient assessment data all at one time and determine whether it is necessary or useful for post-acute care (PAC) providers to collect all of the proposed data.

FY 2022 MEASUREMENT PROPOSALS

Transfer of Health Information to the Provider – PAC. CMS proposes to add this process measure to the FY 2022 SNF QRP. The measure assesses the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was given to the subsequent provider at the time of discharge or transfer from the patient's current PAC setting. The same measure was proposed for inclusion in

the IRF and Long-term Care Hospital (LTCH) QRPs as well. If finalized, IRFs, SNFs and LTCHs would be required to submit measure data beginning with Oct. 1, 2020 admissions and discharges.

The AHA agrees with CMS that sharing patient information in a timely manner is vital to smooth transitions of care and better patient outcomes. The measure also fulfills an IMPACT Act quality measure domain requirement, and its specifications have undergone significant improvements since it was first introduced as a concept several years ago. **However, we urge that the measure receive NQF endorsement before it is adopted in the SNF QRP.** We acknowledge NQF endorsement is not required of SNF QRP measures, and appreciate CMS's intent to "submit the proposed measure to NQF for consideration of endorsement when feasible." Nevertheless, CMS adopts only measures that have already undergone this robust evaluation process and received endorsement. The multi-stakeholder NQF endorsement process determines whether measures meet basic criteria to indicate suitability for use in QRPs and may highlight areas in which the measure's specifications may be tweaked to improve reliability, accuracy and feasibility.

In addition, we question the ability of this process measure to meaningfully improve care. In this case, high performance only would mean that providers are sending a reconciled medication list – not that the subsequent provider received it, or that the list was accurate, or that patients experienced fewer adverse events. As a result, the measure could become a "check-the-box" proxy measure for high-quality care. Although we understand how timely information sharing is associated with improved outcomes, it is hard to imagine how providers – or CMS – could determine whether this measure actually has any effect.

Transfer of Health Information to the Patient – PAC. CMS proposes to add this process measure to the FY 2022 SNF QRP. The measure assesses the proportion of patient stays with a discharge assessment indicating that a current reconciled medication list was given to the patient, family or caregiver at the time of discharge to the home; the same measure was proposed for inclusion in the IRF and LTCH QRPs as well. If finalized, IRFs, SNFs, and LTCHs would be required to submit measure data beginning with Oct. 1, 2020 admissions and discharges.

We reiterate our recommendation above that **CMS wait until this measure receives NQF endorsement before adopting it into the SNF QRP.** In addition, we urge CMS to use the field's experience with transferring information to patients and reporting on this measure to disseminate best practices about how to best convey the medication list. This includes any formats and/or informational elements that are particularly helpful for patients and families. In order to achieve the goals of this measure, merely printing off a list or transmitting it through an electronic health record would not ensure that the patient has any more ability to prevent adverse events.

Update to the Discharge to Community Measure. CMS proposes to exclude baseline nursing facility residents – that is, patients who are admitted to the SNF following a long-term nursing facility stay with no intervening community discharge between the nursing facility stay and hospitalization prior to SNF admission – from calculation of the Discharge to Community measure. Based on public comment suggesting that these patients are far less likely to return to the community, CMS found that the rates of discharge to the community were significantly lower for baseline nursing facility residents compared with patients who did not come from a nursing facility, suggesting that including these patients in measure calculations unfairly skews performance. **The AHA appreciates CMS’s willingness to consider feedback on this measure’s calculation and supports the proposed change to this measure.**

STANDARDIZED PATIENT ASSESSMENT DATA ELEMENT (SPADE) REPORTING

In addition to requiring the adoption of standardized and interoperable quality measures, the IMPACT Act also requires that, for FY 2019 and each subsequent year, PAC providers must report SPADEs. The reporting of these data is required in the PAC QRPs, and as a result, failure to comply with the requirements results in a payment reduction. The SPADEs must satisfy five domains: functional status, cognitive function, special services, medical conditions and comorbidities, and impairments.

In the FY 2018 SNF PPS proposed rule, CMS proposed to adopt SPADEs that would satisfy all five domains. However, the agency did not finalize most of these proposals in response to concerns raised by the AHA and other commenters regarding the speed and magnitude of the additions to already lengthy patient assessment instruments. Stakeholders also were concerned that the data elements had not been tested for use in each specific PAC setting. That is, CMS proposed to adopt for all four settings data elements that were tested only in one PAC setting without determining whether those elements provided reliable and valid data in other settings. Instead, CMS finalized the adoption of SPADEs in just two categories (functional status and medical conditions and comorbidities) based on data elements already finalized for adoption in the various instruments.

In this year’s proposed rule, CMS asserts that SNFs have had sufficient time to familiarize themselves with other new reporting requirements adopted under the IMPACT Act. In addition, CMS cites the results of a recent national beta test of the proposed data elements conducted by its contractors to suggest that SPADEs are now tested adequately. Based on these developments, CMS proposes to add five new SPADEs to the minimum data set (MDS) and modify nine existing elements, which providers would be required to report beginning Oct. 1, 2020. Many of these SPADEs would satisfy the domains required by the IMPACT Act; others would be added under a newly proposed domain on social determinants of health (SDOH). While comparatively less burdensome than the additions proposed in other PAC settings – as most of the elements are already collected in some form through the MDS – we urge CMS to be

cautious in its implementation of some of the SPADEs, specifically those associated with SDOH.

SDOH Data Elements. In addition to the five domains mandated by the IMAPCT Act, CMS proposes to add a new domain related to SDOH, also known as social risk factors. Each of the data elements proposed was identified in the 2016 National Academies of Sciences, Engineering, and Medicine (NASEM) report “Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors,” which was commissioned by the Department of Health and Human Services Assistant Secretary for Planning and Evaluation. In this report, NASEM identified these factors as having impact on care use, cost and outcomes for Medicare beneficiaries.

The AHA does not oppose the concept of collecting SDOH data elements. If implemented appropriately, such data could be useful in identifying and addressing health care disparities, as well as refining the risk adjustment of outcome measures. **However, we urge CMS not to finalize the proposed policy until it can address several important issues around the potential future uses of these elements and the requirements around data collection for certain elements.**

First, the IMAPCT Act requires CMS to assess “appropriate adjustments to quality measures, resource measures and other measures, and to assess and implement appropriate adjustment to payment under Medicare ... after taking into account studies conducted by ASPE on social risk factors.” CMS does not state explicitly in the rule whether it anticipates the SDOH SPADEs will be used in adjusting measures, but we believe the IMPACT Act’s requirements make it likely the SPADEs will be considered for use in future adjustments. Going forward, **we urge CMS to be circumspect and transparent in its approaches to incorporating the data elements proposed in payment and quality adjustments. In part, this can be accomplished using processes like “dry runs” of any adjustments, and by collecting stakeholder feedback before implementing any adjustments.** It is important to understand and account for the impacts social risk factors have on patient outcomes and costs without unfairly penalizing providers who care for vulnerable populations or excusing poor care by pointing to patient characteristics.

Next, CMS notes that, if finalized, SNFs only would need to submit data on the race and ethnicity SPADEs with respect to admission and would not need to collect and report again at discharge, as it is unlikely that patient status for these elements will change. We believe that a patient’s preferred language, need for an interpreter, health literacy, access to transportation, and social isolation also are unlikely to change between admission and discharge; thus, **we urge CMS to require collection of all SDOH SPADEs with respect to admission only.**

Finally, we are unsure that the response options under the race data element are the right ones. From our research, it appears that some of these categories are not

consistent with those used in other government data collection practices, like the U.S. Census or the Office of Management and Budget (OMB). In addition, these select categories are not consistent with the recommendations made in the 2009 Institute of Medicine (IOM) report on Standardized Collection of Data on Race, Ethnicity, and Language, even though CMS cites this report in explaining its proposals.

Specifically, the IOM report recommends using the broader OMB race categories (Black or African American, White, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and some other race) and granular ethnicities chosen from a national standard set that can be “rolled up” into those categories, and ideally the granular options would be tailored to the local market. In addition, the report recommends that each set of categories should include an “Other, please specify: ____” option to allow individuals to self-identify. It is unclear how CMS chose the 14 response options under the race data element and the five options under the ethnicity element, as they do not match the minimum categories used by OMB or the process for capturing granular data recommended in the IOM report.

We worry that these response options would add to the confusion that may already exist for patients about what terms like “race” and “ethnicity” mean for the purposes of health care data collection. In fact, the IOM report states that “[a] lack of standardization of race, ethnicity, and language categories has been raised as one obstacle to achieving more widespread collection and utilization of these data.” **CMS should confer directly with experts on the issue to ensure patient assessments are collecting the right data in the right way before these SDOH SPADEs are finalized.**

SNF VALUE-BASED PURCHASING (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 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 funding pool was created by reducing each SNF’s Medicare per-diem payments by 2%; as permitted under the statute, CMS distributes 60% of the pool back to SNFs in the form of incentive payments. In this proposed rule, CMS proposes only nominal changes to the SNF VBP program, including policies for displaying scores when SNFs have fewer than 25 eligible stays during the baseline or performance periods.

Renaming the Potential Preventable Readmission Measure. In the FY 2017 SNF PPS final rule, CMS adopted the SNF 30-Day Potentially Preventable Readmission Measure (SNFPPR), which PAMA requires CMS to use in the SNF VBP program instead of the current all-cause all-condition readmission measure “as soon as practicable.” In this rule, CMS states that it would change the name of the SNFPPR measure to “Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge.” The agency believes this will reduce confusion with a similarly named potentially preventable

measure that is used in the SNF QRP, “Potentially Preventable 30-Day Post-Discharge Readmission Measure for Skilled Nursing Facility Quality Reporting Program,” which assesses readmissions post-SNF discharge (as opposed to post-hospital discharge).

The AHA supports this change, but also encourages CMS to revisit the timeline for which it foresees adopting the potentially preventable readmissions measure into the SNF VBP program. In prior rules, CMS has stated that it believes FY 2021 to be the first opportunity to replace the current measure with the potentially preventable measure; we believe that this measure is a more accurate representation of SNF quality of care, and thus encourage CMS to provide firm plans for the measure’s implementation and to do so as soon as possible. We appreciate the small number of programmatic changes that CMS has proposed for the SNF VBP program. The program is still new, and we believe that monitoring performance across multiple years before instituting additional changes to the program will lead to more useful data, as SNFs can better track changes in their performance to initiatives they are implementing on the ground.

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 regarding the payment provisions; or Caitlin Gillooley, senior associate director of policy, at cgillooley@aha.org pertaining to the quality-reporting provisions.

Sincerely,

/s/

Thomas P. Nickels
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