June 9, 2020

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1737-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 Value-Based Purchasing Program for Federal Fiscal Year 2021 (CMS-1737-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

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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.

With the inception of the PDPM, CMS undertook an effort to modernize and increase the predictive power of the rate setting methodology. 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 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 SNF geographic reclassification procedure 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.

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.

Several existing Federal Drug Administration (FDA) approved pharmaceuticals are being tested and/or used on a compassionate basis for the treatment of Coronavirus. Other drugs may emerge that exhibit clinical efficacy and be approved for use by the FDA. If any of these drugs are administered in SNFs and would otherwise meet the consolidated billing statutory criteria, they should be excluded on an expedited basis and considered separately billable.

Finally, we 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 can create 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 disadvantage financially and in competition for scarce front-line staffing. 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.

Technical Updates to PDPM ICD-10 Maps

LeadingAge NY supports the proposed changes to the ICD–10 clinical category mappings utilized in the SNF PDPM, specifically as they recognize that the PDPM clinical category should reflect whether the patient had a major procedure during the prior acute care inpatient stay that impacts the plan of care.

The ICD-10 official coding and reporting guidelines have been modified to incorporate diagnoses of the 2019 novel coronavirus disease (COVID-19); respiratory illnesses due to COVID-19; exposure to COVID-19; screening for COVID-19; symptoms of COVID-19 without definitive diagnosis; and asymptomatic patients with positive tests. To contain the spread of COVID-19, federal and state agencies have required SNFs to institute enhanced infection control procedures and take several other actions including screening/testing of staff and residents; isolating/cohorting patients; and enhancing reporting and communications with government agencies, residents and families. These measures have resulted in major staffing, equipment/supplies, training and administrative cost increases to SNFs that are not accommodated by existing PDPM rates.

CMS should utilize its administrative authority to ensure that the added costs associated with providing SNF care during the current pandemic are recognized when setting payment policy. In this regard, we recommend that CMS incorporate an increased payment modifier in the PDPM for ICD-10 diagnoses that can be attributed to COVID-19 and its symptoms to reflect the extraordinary costs to provide care during the pandemic. This approach should be taken retrospectively in Fiscal Year 2020 (FY20) and prospectively in FY21. Given the possibility that COVID-19 continues to impact the delivery of SNF care beyond FY21 as well as the potential for additional, future outbreaks requiring similar infection control measures, we suggest that CMS institute a permanent payment modifier that would be applied not only for COVID-19 but for potential future outbreaks.

SNF Value-Based Payment Program

The proposed FY21 SNF PPS rule does not include any significant changes to the SNF Value-Based Payment (VBP) Program. However, we are concerned about the implications of COVID-19 for SNF

utilization and how the current emergency could affect future SNF rate adjustments based on the VBP program.

CMS utilizes claims data to determine the numerical values of the SNF 30-Day All-Cause Readmission Measure (SNFRM), which determines payment adjustments under the SNF VBP program. In a March 27, 2020 memo, CMS indicated that it would be invoking the SNF VBP program's Extraordinary Circumstances Exception Policy and exclude qualifying claims from the SNFRM calculation for the period Jan. 1 – June 30, 2020. In this regard, we are concerned that a limited, potentially unrepresentative data set for 2020 could be compared to a 12-month baseline data set in a future year of the VBP program to determine individual SNFs' performance and incentive payments in future years. SNFRM performance from calendar year 2020 will first impact SNF PPS rates in FY22 when a SNF's incentive payment will be determined by comparing its performance for part of FY20 (i.e., Oct. 1 – Dec. 31, 2019 and July 1 – Sept. 30, 2020) to a full year of performance in FY18.

We are concerned that comparing partial year data to a complete year of baseline data will not result in a valid comparison of SNFs' performance on hospital readmissions. The number of qualifying admissions would be expected to be far lower due to the partial year, thereby increasing the denominator and increasing the volatility of the measure. Secondly, comparisons of avoidable hospital use between the pre-COVID-19 era and the COVID-19 period may not be valid due to variable circumstances including COVID-19 infections requiring hospitalizations; moratoria on hospital elective procedures; waivers of the 3-day qualifying stay requirement; and treatment-in-place in SNFs.

Under these circumstances, it would be invalid and inequitable to compare nursing homes nationally or even within a state based on avoidable hospital use since the number of COVID-19 cases and the timing of the COVID-19 outbreaks have been so variable. Furthermore, each state took its own actions to combat the spread of coronavirus and as such, a SNF's performance on readmissions and other quality measures has likely been influenced due to the variations in state policies and timing of spread of the virus.

CMS should carefully consider and address in future rulemaking how it will approach calculations and payment adjustments under the SNF VBP for time periods when performance or baseline are impacted by pandemic.

SNF Quality Reporting Program

The proposed FY21 SNF PPS rule does not include any significant changes to the SNF Quality Reporting Program (QRP). However, we are concerned about the implications of COVID-19 for SNF public reporting of SNF quality and performance data, and how the current emergency could affect future SNF rate penalties for underreporting.

CMS waived the requirement for SNFs to report data for the SNF QRP for the period Oct. 1, 2019 through June 30, 2020. The SNF QRP includes a penalty based upon whether each SNF completes 100 percent of the required Minimum Data Set (MDS) fields needed to calculate the QRP measures at least 80 percent of the time. SNFs continue to complete MDS assessments despite this waiver, as MDS data are needed to set PDPM rates, but in prioritizing their work during the pandemic may have not

completed all the data fields needed for QRP compliance. Based on these extraordinary circumstances, CMS should hold all SNFs harmless from the 2 percent penalty for FY22 (when it would first have an impact) and beyond if future rate years are impacted by QRP reporting during the COVID-19 pandemic.

Given that the quality data reported during the COVID-19 emergency will be unrepresentative of SNF care in general, CMS should forgo public reporting of the limited data collected for the VBP and QRP programs during the pandemic emergency. These data cannot be validly compared across SNFs with COVID-19 cases and those without, nor across variably impacted states and regions, and would not help consumers to make sound decisions about accessing SNF care.

More broadly, we are concerned about the impact of the pandemic on the validity of the Five-Star Quality Rating System from the perspectives of data collection, survey inspection, quality outcomes and systemic response. While outside of the confines of this rulemaking, we respectfully urge CMS to carefully consider and address this issue.

Addressing Other COVID-19 Related Costs

LeadingAge NY and its members are appreciative of the funding that has been distributed under the Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund to SNFs in New York. However, we have no assurance that the amounts provided will compensate SNFs for the added staffing, supplies, training and administrative costs or the major disruptions in revenue that have occurred as a result of COVID-19. Earlier in these comments, we recommended that CMS institute a payment modifier in the PDPM to confer additional payments on SNFs for the added costs of treatment. However, if this is not instituted until FY21, it could leave SNFs under-compensated for these costs in FY20. Furthermore, this recommendation would not address the major disruptions in volume and revenue that SNFs have experienced, particularly in the most impacted areas.

CMS should gather data on increased SNF costs and changes in utilization/revenue, and utilize this information to determine the amount of additional distributions from the Provider Relief Fund and/or revisions to SNF PPS rates needed to compensate facilities for these added costs and reduced revenues.

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