August 24, 2017

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1686–ANPRM
P.O. Box 8016
Baltimore, MD 21244–8016

RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology (CMS-1686-ANPRM)

Dear Ms. Verma:

I am writing on behalf of LeadingAge New York to provide our comments on the above-captioned Advanced Notice of Proposed Rule Making. 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.

We support the Centers for Medicare and Medicaid Services (CMS) goal of ensuring that resident care decisions appropriately reflect each resident's actual care needs. We agree it is appropriate to derive payment from objective resident characteristics to the extent possible. While it is beyond the scope of our ability to validate the modeling CMS and Acumen, LLC have performed, we appreciate the Technical Expert Panel (TEP) discussion process and the extensive analyses that CMS has engaged in to identify characteristics and combinations of characteristics that drive care needs and costs.

While optimistic that RCS-1 represents an improvement for both SNF residents and providers, we are aware of the magnitude of the change and are wary of the ambitious implementation timeline contemplated, given the need for training and systems redesign on top of several other initiatives SNFs are implementing concurrently. Our comments on various aspects of the RCS-1 model follow.

Overall approach. We believe that the increased focus on the nursing component and a separately adjusted non-therapy ancillary component will be more reflective of care costs. We believe that provider attention to resident needs and CMS oversight will ensure that appropriate levels of therapy continue to be provided even as the incentives under the methodology are significantly altered. In this regard, we note that the Fiscal Year (FY) 2014 expenditure data which were used as the basis for comparison between the current system and RCS-1 may not be fully reflective of the effects on provision of therapy services of the *Jimmo v. Sebelius* Settlement Agreement.

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Both the RUG-III and RUG-IV classification systems and accompanying payment methodologies have shown inherent limitations in accurately recognizing and reimbursing for cognitive impairments in some cases. We support the use of a combined NIMS/CPS score to better capture the varying levels of impairment that drive care costs. As with other components that would be newly implemented as part of RCS-1, it will be critical for CMS to monitor whether the construct accurately reflects the costs associated with serving individuals with cognitive impairments, especially those with minor impairments.

We also support refinements that attempt to eliminate ADL measures that may be confounded by facility procedures rather than resident characteristics by using transferring, toileting and eating to predict physical and occupational therapy need. If RCS-1 is implemented, it will be important for CMS to closely track and monitor resident characteristics that may be identified as resulting in insufficient reimbursement so that adjustments may be made to ensure these residents are served.

We believe that the model largely meets the goals that CMS is seeking to achieve except for simplicity; while the separate components are clearer in their individual development, the overall methodology is more complex in that it offers more possible component combinations (each separately adjusted) resulting in more, and possibly less predictable, payment levels. For purposes of quantitatively assessing the goal of creating a model that compensates SNFs accurately based on the complexity of the particular beneficiaries they serve and the resources necessary in caring for those beneficiaries, it may be helpful to calculate the overall coefficient of determination (i.e., R^2) for RCS-1 and compare it to the R^2 for the RUG-IV system, initially using historical data.

Non-therapy ancillaries. LeadingAge NY supports the efforts within RCS-1 to refine the case-mix adjustments applied to non-therapy ancillary (NTA) costs, particularly for residents with multiple comorbidities. These costs are subject to considerable variation, which is not properly reflected in RUG-IV. We would recommend validation of the assumption – which is based on the 1998 calculation – that NTA costs comprise 43 percent of the nursing component, utilizing current claims and cost data. We would also recommend that CMS consider either adopting an outlier policy for high-cost medications that are not excluded from SNF consolidated billing requirements, or expanding the list of high-cost medications that are exempt from consolidated billing.

Limitations on group and concurrent therapy. We support efforts aimed at ensuring that the mode of therapy provided is appropriate to the clinical needs of the resident, whether the therapy is provided individually, concurrently or in a group. Any limitations placed on the proportion(s) of therapy minutes that are provided concurrently or on a group basis should also consider the local availability of therapy personnel. In particular, certain types of therapy personnel (most notably occupational and speech therapists) may not be as widely available in rural areas as they are in other geographic regions.

Interrupted stay policy. We recommend that CMS consider the possibility of resetting the variable per diem adjustment schedule in cases when a resident is discharged from a SNF and returns to the same SNF within 3 calendar days after having been discharged, if the resident has undergone a significant change and the facility completes a significant change assessment. It is possible that such an individual could be hospitalized on a short-term basis and be diagnosed with one or more conditions that could significantly change his/her need for NTA or therapy services following discharge.

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 to SNFs for initial implementation. SNFs continue to be impacted by a two percent sequestration reduction, face a FFY 2018 market basket increase lower than the market would otherwise dictate due to MACRA provisions, and are subject to a potential two percent reduction by the SNF Quality Reporting Program (QRP). Additionally, starting next year the SNF Value-Based Purchasing (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 are also implementing revised Requirements of Participation (ROPs) and will need to engage in training and education related to upcoming MDS changes and a new survey process. 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. In this regard, CMS should consider readjusting the adjusted RCS-1 case-mix weights following implementation to reflect actual changes in PPS Part A spending under the new system in relation to the budget baseline.

Education and training needs. As described in the Advance Notice, case-mix adjustment under RCS-1 would be based much more heavily on diagnoses and clinical conditions. Additionally, the Notice indicates that CMS is contemplating basing the payment for the entire SNF stay on information provided on the 5-day MDS assessment (with the opportunity to update for a significant change in condition). 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 correct. If implemented as described, RCS-1 is likely to 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.

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 RCS-1 will 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.

Wage index adjustment. CMS should use RCS-1 as an opportunity to rationalize all parts of the rate setting methodology including implementing a SNF wage index. Direct care labor inputs represent a significant proportion of SNF costs. For this reason, 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.

Under the RCS-1 model, CMS indicates that it is considering continued use of the hospital inpatient wage data in developing a wage index to be applied to SNF payments. 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 standardized and 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.

Assessment completion schedule. CMS is considering using the 5-day SNF PPS scheduled assessment to classify residents under the RCS-1 model for the entirety of their Part A SNF stay while allowing changes if criteria for a significant change in condition are met. While we support a reduction in the number of MDS assessments that would be required, the 5-day assessment may be too early in the stay to be appropriate for locking in the resident into a payment category. A complete assessment of the resident as well as full information regarding any preceding hospital stay may not yet be available at that time. CMS should consider permitting corrections to the 5-day assessment if additional information is obtained that would categorize the resident into a different RCS-1 category. Patient records that a SNF receives from a hospital at the time of admission are likely to indicate the cause for hospital admission, not the final diagnosis or diagnoses.

Additionally, CMS should be prepared to make any necessary changes to 5-Star quality measures, the SNF QRP as well as SNF VBP calculations to ensure complete and accurate data from fewer assessments.

Implementation timeline. CMS notes that it intends to propose case-mix refinements for the FY 2019 SNF PPS proposed rule and requests comments on how much lead time providers and other stakeholders should receive before any finalized changes are implemented. 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, October 2018 is likely to be too soon to implement this change. 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.

Potential impacts on other federal initiatives. The major shift in emphasis of the RCS-1 system from service provision to patient 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 RCS-1 and make any needed revisions to the following programs and any other federal initiatives that may be affected:

- The quality measures included in the 5-Star rating system, particularly for short-term residents who may evidence more clinical conditions and functional limitations in response to RCS-1;
- 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 SNF 30-Day Potentially Preventable Readmission Measure 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
- Implementation of the new RoPs and survey process.

Potential Impact on States. The notice 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.

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 RCS-1 resident classification system that states could use to case-mix adjust Medicaid rates of payment.

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