June xx, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1645-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1645-P: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research

Dear Sir/Madam:

I am writing on behalf of LeadingAge New York to provide our comments on the above-captioned proposed rule. LeadingAge New York represents nearly 500 not-for-profit and public providers of long term care and senior services throughout New York State, including nursing homes 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.

Our comments on various aspects of the proposed rule follow.

Wage Index Adjustment (Section III.D.)

The Centers for Medicare & Medicaid Services (CMS) proposes to continue use of the hospital inpatient wage data in developing a wage index to be applied to SNF payments. We believe; however, 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.

Consolidated Billing (Section IV.B.)

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. This agent is labeled by the Celgene Corporation under National Drug Code # 59572-0410-28. We could not locate a HCPCS code for this agent other than J8999 (Prescription drug, oral, chemotherapeutic, Not

Otherwise Specified). The Average Wholesale Price for a 28-day supply of Revlimid 10mg capsules exceeds $18,000. We believe that this agent meets the statutory criteria of high cost and low probability in the SNF setting.

SNF Value-Based Purchasing (VBP) Program (Section V.A.)

General Comments

LeadingAge NY agrees that VBP – if properly designed and administered – can provide incentives to promote higher quality and more efficient health care for Medicare beneficiaries. However, we are concerned that a VBP program that relies exclusively on a hospital readmission measure to determine facility quality performance and value-based incentive payments ignores other important quality, structural and process elements of SNF service delivery.

In this regard, we question whether Subsections (g) and (h) of Section 1888 of the Social Security Act actually require the VBP program to be based exclusively on performance on a hospital readmission measure, or whether other indicators such as quality measures, staffing levels and survey inspection performance could also be factored in to determine facility performance and incentive payments. Minimally, there should be a coordinated approach and shared goals/objectives between the VBP program, the SNF Quality Reporting Program and the Staffing Data Collection initiative.

Skilled Nursing Facility 30-Day Potentially Preventable Readmission Measure (SNFPPR)

LeadingAge NY agrees that reducing hospital readmissions is important for quality of care and patient safety, and that preventing potentially avoidable hospitalizations is a policy imperative of the Triple Aim. Our specific comments on the SNFPPM follow:

- The SNFPPR hospitalization measure appears to be a more refined measure of avoidable hospital use than the SNF 30-Day All-Cause Readmission Measure (SNFRM). It reflects conditions associated with potential prevention and excludes unplanned hospitalizations that are less likely to be attributable to SNF quality of care.
- Adopting the SNFPPR as soon as practicable is a laudable goal, but proper refinement and testing of the measure is more important than expediency.
- While we understand that CMS is attempting to align hospitalization measures across its payment programs, we are concerned about the use of differing measures even within a service line. For example, the hospitalization measure utilized in the Nursing Home Five-Star Quality Rating differs from the proposed SNFPPR. Such differences in measures, combined with the temporary use of the SNFRM, are likely to cause confusion among consumers, providers and payers.
- The longer-term goal should be to align this measure with other relevant hospitalization measures planned for use. For example, states such as New York are working with CMS to develop VBP programs for their Medicaid programs under Section 1115 waiver authorities and as part of the Financial Alignment Initiative. With efforts underway to integrate care for dual eligible beneficiaries, efforts to reduce avoidable hospital use would be reinforced by ensuring

complementary approaches to hospitalization measures between the Medicare and Medicaid programs.

- While we are pleased this measure would not require collection or submission of additional data by SNFs, basing it on Medicare fee-for-service (FFS) claims data seemingly results in some inherent limitations. Specifically, we are concerned about the time lag between the end of the measurement period and the availability of clean, adjudicated claims data, particularly given the one-year timeframe for claim submission. The proposed rule relies on a 90 day runoff period, which seeks to balance the issues of completeness and timeliness. We encourage CMS to conduct analyses to determine – for purposes of the SNFPPR and any SNF Quality Reporting Program measures that are claims based – an optimal run off period or some other method for adjusting for submission and adjudication of claims that occur outside of the run off period.
- SNFs do not have access to the data used to calculate the SNFPPR and, therefore, will not be able to validate their rates with the CMS outcome data. Of particular concern is the inability of SNF providers to access primary discharge diagnoses in order to validate the reason(s) for hospital admission.
- Certain SNFs specialize in serving medically subacute patients, as well as specialty populations that are associated with higher rates of hospitalization. The risk adjustment variables that are utilized should not inadvertently penalize SNFs that offer these programs. In this regard, while we are pleased to see that the risk adjustment variables include an indicator for End-Stage Renal Disease (ESRD), we are concerned that an indicator for mechanical ventilator care – which we believe places patients at a higher risk for hospital use – is not included.
- We agree with the recommendation to reflect socioeconomic status (SES) in risk adjustment. However, we are unclear as to which SES 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.
- We question whether the type of location to which the beneficiary is discharged should be considered as a risk adjustment variable. For example, rural settings are often associated with more limited access to home health care services than urban and suburban locations. Access to services could have a bearing on the frequency of PPRs in the post-SNF discharge period.
- We are concerned that the SNF would be held responsible for PPRs that occur when other care coordination arrangements are in place (e.g., Accountable Care Organizations, Medicare bundled payments, Medicaid managed care arrangements for dual eligibles, etc.) for the beneficiary, particularly in the post-SNF discharge period. The SNF may or may not be a direct party to these arrangements, which incorporate payments for care coordination and quality/financial measure expectations. We believe that these overlapping initiatives would cause confusion among providers, skew results and incentives, and diffuse authority and accountability for the outcomes of care.
- Medicare SNF Part A lengths of stay are decreasing in many cases, particularly for total joint replacement care which may comprise only 7-10 days. Under these circumstances, we question whether the SNF should be held accountable for PPHs in the post-SNF discharge period for episodes of care in which the actual SNF days represent a small proportion of the total Medicare-covered services provided.
- We are concerned that the list of conditions for defining PPRs for 30-days post-SNF Discharge may be too broad. Specifically, it seems quite possible that the measures related to inadequate management of infection and inadequate management of other unplanned events could

describe conditions with onset after the SNF stay for which the SNF should not be held responsible.

Performance Standards

- LeadingAge NY supports CMS's proposal to define the achievement threshold for quality measures specified under the SNF VBP program as the 25th percentile of national SNF performance on the quality measure during the applicable baseline period. Given that the SNFRM has not been used heretofore for payment purposes, we believe the 25th percentile strikes an appropriate balance between level of achievement and implications for payment.
- Having said that, we support further CMS analysis of SNFRM data to determine how the 25th percentile achievement threshold would impact SNFs' scores under the proposed scoring methodology and resulting payments.
- We support the use of the proposed improvement performance standard to incentivize facilities to continuously improve their performance on the quality measures under the SNF VBP Program. However, we are unclear as to how measurement of improvement will occur as the transition is made from the SNFRM to the SNFPPR.
- We are concerned that the total amount of VBP incentives for achievement and performance improvement under the program can be no greater than 70 percent of the total amount of reductions to SNFs' payments for the FY, and about what effect this limitation will have on the resulting payments.

Public Reporting

- We are pleased that SNFs will have an opportunity to review and correct their performance information prior to its posting on *Nursing Home Compare*. The information furnished to the SNF for this purpose should incorporate sufficient detail for the facility to validate its measure and ranking, including specifics on the hospital discharge diagnoses and how they compare to the admission diagnoses and treatment received in the hospital as well as risk adjustments made to the facility's data.
- Public reporting of SNF-specific performance scores should be accompanied by explanations of the methodology used; what the potentially avoidable admission measure is intended to show; and any limitations associated with the measure.

SNF Quality Reporting Program (QRP) (Section V.B)

As part of the rule, CMS proposes to adopt three new resource measures for the SNF QRP – Medicare Spending per Beneficiary, Discharge to Community and Potentially Preventable 30-Day Post-Discharge Readmissions – and one new quality measure, Drug Regimen Review Conducted with Follow-Up for Identified Issues.

Our comments on these measures follow:

- We appreciate the acknowledgment that socioeconomic status can have a significant bearing on the outcomes of care. How the SES is applied is also critically important and must be well-considered prior to implementation. As previously noted, we are unclear as to which SES

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. We are pleased to note that there is considerable work being done on this issue by the National Quality Forum, the HHS Office of the Assistant Secretary for Planning and Evaluation and the Institute of Medicine, but there is as of yet no current standardized approach or methodology to address SES in this context. Perhaps at the outset this research will identify one or more statistically significant SES factors that can be used to peer group SNF providers serving like numbers of such beneficiaries and compare performance across these peer groups of facilities.

- Failure to adequately and validly account for complex-care individuals will result in poorer quality scores for the three proposed QRP resource use measures, thereby penalizing SNFs that provide care to medically-complex and socioeconomically disadvantaged residents, and threatening access to care.
- For those measures that are calculated by CMS from encounter data, the review and correction process may not provide SNFs with enough information to allow them to validate their measure values.
- As with our previous comment on alignment of hospitalization measures, we also recommend aligning these quality measures with those in use or planned for use in other major CMS initiatives including the Financial Alignment Initiative, the CMS Medicare value-based payment program, and Medicaid managed care initiatives under Section 1115 waiver authorities.
- As part of our discussion on the SNFPPR, we expressed concern that SNFs would be held responsible for the outcomes of care when other care coordination arrangements are in place (e.g., Accountable Care Organizations, Medicare bundled payments, Medicaid managed care arrangements for dual eligibles, etc.) for the beneficiary. We believe this same concern applies to the additional QRP measures. The SNF may or may not be a direct party to these care arrangements, which incorporate payments for care coordination and quality/financial measure expectations. We believe that these overlapping initiatives would cause confusion among providers, skew results and incentives, and diffuse authority and accountability for the outcomes of care.
- Furthermore, there may be meaningful SES, clinical or other differences between beneficiaries in the Medicare FFS program (for whom these measures are reported) versus Medicare Advantage (MA) enrollees that could have a material bearing on comparisons between facilities with varying numbers of FFS and MA patients on one or more of these measures. This possibility should be investigated as part of the research being undertaken on SES factors.
- The additional QRP measures necessitate increased communication and collaboration between SNF and hospitals, other post-acute care providers, practitioners and other Medicare providers/suppliers. However, in stark contrast to its policies for hospitals and physician practices, the federal government has not provided SNFs and other post-acute care providers with financial support to deploy electronic medical records or engage in health information exchange. If SNFs and other post-acute care providers are expected to collaborate with other providers on transitions of care, to bring down the cost of post-acute care, to reduce avoidable hospital use and to conduct effective drug regimen reviews, they should have access to financial support for health information technology and health information exchange.

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