LeadingAge New York

June 19, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1622-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-1622-P: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) for FY 2016, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and Staffing Data Collection

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 over 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. 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.

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

<u>General Comments</u>

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

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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 included in this proposed rule.

SNF 30-Day All-Cause Readmission Measure (SNFRM)

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 SNFRM follow:

- 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 release of clean, adjudicated claims data. The lengthy delays that could result in determining facility results and calculating the value of any VBP incentive payments would seem to be at odds with the statutory intent of timely notice and payment.
- SNFs do not have access to the data used to calculate this measure 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 patient characteristics, comorbidities and health status variables that are used in the risk adjustment model should not inadvertently penalize SNFs that offer these programs.
- We support the proposal to exclude from the measure those patients whose prior proximal hospitalization was for the medical treatment of cancer, and encourage CMS to undertake or review further studies to determine if other populations within SNFs should be excluded based on an illness with a differential trajectory and mortality rate.
- 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 value-based payment programs for their Medicaid programs under Section 1115 waiver authorities and as part of the Financial Alignment Initiative. CMS has also announced its own value-based payment initiative for the Medicare FFS program. 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.

Public Reporting

- SNFs should 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 readmission measure is intended to show; and any limitations associated with the measure.

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

General Comments

- LeadingAge NY recommends the use of a consistent definition of the short-stay population among all three QRP measures. The current CMS short-stay definition includes residents in the facility for less than or equal to 100 days; the Falls measure (NQF #0674) and Function measure (NQF #2631) define the target population as "Medicare Fee-For-Service" while the Pressure Ulcer measure (NQF #0678) defines it as "those who have accumulated 100 or fewer days in the SNF/NH…". This could result in different denominators being used for these measures, which is likely to be confusing to providers and other users of the data.
- 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.

Percent of Long Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function (NQF #2631)

- This is a process measure that will require the addition of a new MDS section to include additional/differently defined activities of daily living than the current Section G. Because this measure will flag residents as long as any discharge goal is identified even it that goal is not achieved, we believe there will be very little variation across facilities. As a result, the measure will not effectively incentivize improved quality of care, although it will increase the administrative burden on nursing homes by adding assessment time and training costs.
- The name of the measure (i.e., "Percent of Long Term Care Hospital Patients…") is misleading since SNFs, Inpatient Rehabilitation Facilities, and Long Term Care Hospitals will all be required to report data, not just Long Term Care Hospitals.

Percent of Residents or Patients with New or Worsened Pressure Ulcers (NQF #0678)

- The SNF time window for lookbacks is different than the current CMS measure - "look back may be as many as 100 days" whereas the current measure is 120 days. We recommend maintaining consistency.

Percent of Residents Experiencing One or More Falls with Major Injury (NQF #0674)

- According to the denominator specifications, this measure is applicable for Medicare FFS beneficiaries only, yet it includes all assessment types – OBRA and PPS. Are the OBRA assessments considered in the lookback scan? Does this measure include long-stay and short-stay residents, as long as they are Medicare beneficiaries? Answers to these questions should be provided in a final rule.

- Items for measurement include all falls, and yet only major falls are counted in the numerator. This is confusing, and should also be clarified in a final rule.

Staffing Data Collection (Section V.D.)

The proposed rule would require long-term care facilities to electronically submit quarterly payroll data to include the category of work performed and the hours of work provided by each category per resident per day – distinguishing facility employees from agency and contract staff – and that is verifiable and auditable, beginning July 1, 2016. Required information would include submission of each individual's start date, end date (if applicable) and hours worked for the purpose of calculating turnover and retention.

LeadingAge New York member nursing homes have raised the following concerns and questions about the proposed requirements, which should be addressed in a final rule and subsequent guidance:

- Every employee will need to have a unique employee number assigned for tracking and reporting purposes. This may require payroll and other systems modifications.
- Payroll vendors are not yet prepared to accommodate the required reporting.
- Providers may incur compliance costs associated with modifying their own payroll systems or from payroll vendors needing to make such modifications.
- It is not clear when the payroll submissions are due (i.e., how much time providers will be given after the end of the quarter to make their submission).
- What are the applicable start and end dates that a facility would report for contract and agency staff? These workers can be used intermittently over indeterminate time periods.
- How will the requirements take into account hours worked beyond the standard workweek by salaried/exempt direct care staff?
- How will the reporting distinguish between direct care hours worked and hours worked on management and other responsibilities by a salaried employee? For example, nurse managers may split their time between direct care and management functions.
- It is unclear how the number of days will be gathered from the submitted data for purposes of determining hours of care per resident day. Given the desired level of accuracy in reporting of hours worked, we would advocate for an accurate and unobtrusive method for collecting information on the number of resident days provided in each reporting period.

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