June 17, 2016

Mr. Andy Slavitt
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4159-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: AHCA Response to Proposed Rule, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research; Proposed Rule. Federal Register, Vol. 79, No. 81, April 25, 2016. CMS-1645-P

Dear Mr. Slavitt,

The American Health Care Association and the National Center for Assisted Living (AHCA/NCAL) represents over 13,000 skilled nursing facilities (SNFs), or 1.063 million beds, and more than 209,000 assisted living residence (ALR) beds. With such a membership base, the Association represents the vast majority of SNFs and a rapidly growing number of ALRs.

We appreciate the opportunity to comment on the SNF Prospective Payment System (PPS) Proposed Rule for fiscal year (FY) 2017. To provide the Centers for Medicare and Medicaid Services (CMS) with a cohesive and succinct set of comprehensive comments, AHCA/NCAL has constructed our comments in the following manner:

- **Executive Summary** – The executive summary provides a comprehensive overview of the Association’s perspective on the Notice of Proposed Rule Making (NPRM), including how we view the role of Original Medicare coverage of Part A SNF services within the broader context of Medicare payment and service delivery evolution, and a summary of our recommendations by section; and

- **Section-by-Section Comments** – Each section is drafted as a stand-alone document specific to a section of the rule. The appendices are Section 1 –
Market Basket and State Minimum Wage Laws; Section 2 – Unadjusted Federal Rate Per Diems; Section 3 – Wage Index; Section 4 – SNF Value-Based Purchasing Program; Section 5 – SNF Quality Reporting Program; Section 6 – Payment Models Research; and Section 7 – Collection of Information Requirements. The sections are comprised of an introduction, summary of our recommendations, and a detailed discussion of our observations on the pertinent rule section and rationales for our recommendations.

We look forward to our ongoing dialogue with CMS about SNF payment and quality programs and, again, appreciate the opportunity to comment. If you have questions about any of our comments, please contact Mike Cheek at (202) 454-1294 or David Gifford at (401) 487-3835.

Sincerely,

Mark Parkinson
President & CEO
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Executive Summary

Overview

The American Health Care Association (AHCA) represents more than 13,000 non-profit and proprietary skilled nursing facilities (SNF), sub-acute centers and a rapidly growing number of assisted living residences (ALR). By delivering solutions for quality care, AHCA aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care (LTPAC) in our member facilities each day.

As the voice in Washington for the vast majority of America’s SNFs, AHCA’s responsibility is to ensure that our profession’s position on key legislation and proposed regulations is effectively communicated to the appropriate governmental bodies. This document summarizes AHCA’s comments on the Medicare Program, Prospective Payment System (PPS) and Consolidated Billing for Skilled Nursing Facilities FY 2017, SNF Value-Based Purchasing (VBP) Program, SNF Quality Reporting Program (QRP), and Payment Models Research, Proposed Rule, Federal Register, Vol. 81, No. 79, April 25, 2016. CMS-1645-P. We appreciate the opportunity to comment on the SNF PPS Proposed Rule for FY 2017.

Embracing PAC Payment and Quality Modernization

Since 1965, the Medicare program has adapted and evolved to better serve patients and their families. A key component of these changes is how Medicare reimburses for services provided for patients. To help curb costs and cap spending in the 1990s, Medicare payment evolved from a cost-based approach to the current prospective payment system – a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. Medicare has reached another pivotal point driven by a growing older adult population that will be in need of more health care services. Medicare must adapt to meet the needs of Medicare beneficiaries and providers who deliver critical services, including post-acute care (PAC).

New payment approaches will be implemented that reward providers for quality and value. AHCA supports the implementation of a VBP program for SNFs, and we look forward to continuing to work with CMS to develop an approach that provides cost savings, ensures quality care, and is fair to providers.

To ensure that value and quality go hand-in-hand under new payment approaches, AHCA has implemented a Quality Initiative for its members. It is intended to raise the bar in care delivery and set measurable goals for quality improvement in key areas. This year, AHCA has broadened its Quality Initiative to further improve the quality of care in America’s skilled nursing care centers. The expansion challenges members to apply the Baldrige Performance Excellence Framework to meet measurable targets in eight areas with a focus on three key priorities: improvements in organizational success, short-stay/post-acute care, and long-term/dementia care. These areas are aligned with the CMS
Quality Assurance/Performance Improvement (QAPI) program and federal mandates, such as Five-Star and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

**Evolving SNF Statutory and Regulatory Environment**
The long term care profession is preparing for an array of sweeping regulatory and payment changes. First, on July 16, 2015, CMS promulgated Medicare and Medicaid Programs, Reform of Requirements for Long-Term Care Facilities, Proposed Rule, *Federal Register*, Vol. 80, No. 136, CMS-3260-P. Many of the updated and/or new provisions entail new provider operational costs. Below, we highlight a few key areas of concern which make ensuring payment is accurate critical:

1. **Array of Changes at Once.** There are numerous changes and increased requirements in the proposed rule. Some of these include:

   - Quality Assurance and Performance Improvement (QAPI) plan development
   - Compliance and Ethics program
   - More extensive Infection Control requirements
   - A required facility assessment that will be used to determine “sufficient staff”
   - Requirements related to behavioral health services
   - Determining staff competency
   - Credentialing of residents’ attending physicians
   - Employees and contracted direct care, nursing service and food and nutrition service staff are expected to meet competency, knowledge and skill requirements
   - Additional training requirements for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles
   - Utilization of culturally competent, trauma-informed approaches to care for patients/residents

*AHCA concerns: There are many new requirements all at one time. AHCA has recommended these be phased-in over five years, with compliance required one-year post phase-in of individual requirements. The cost of implementation is not covered by Medicaid or Medicare.*

2. **Transitions of Care.** Transfer or discharge must be documented in the resident’s clinical record and appropriate information communicated to any receiving setting, including homes with home health services, hospice setting, assisted living, etc. Documentation includes 18 specific items that must be included (p. 42255). When the resident is being transferred for the resident’s safety and welfare, in addition to the previously mentioned 18 items that must be documented, the center must document the specific resident needs it cannot meet, the center’s attempts to meet the needs, and the services available at the
receiving facility that will meet the resident’s needs (p. 42189-42190; 42255).

AHCA concerns: This may result in the need for additional staff resources within a center that are not covered by Medicare or Medicaid.

AHCA’s list of key concerns with the proposed Requirements of Participation (RoPs) are available here. For purposes of our comments on our payment rule, again, we urge CMS work closely with the profession to ensure payment is accurate and sufficient to address these new federal requirements associated with Medicare program participation. Additionally, AHCA recognizes that CMS faces unique challenges in the SNF payment rule. In the coming years, CMS must weave together new SNF payment rule provisions, including VBP and QRPs. Although not new for other Medicare providers, VBP and QRP remain untested among SNFs for purposes of Medicare payment.

Specifically, going forward, Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) added new subsections (g) and (h) to section 1888 to the Social Security Act (Act). The new Subsection 1888(h) authorizes establishing a SNF VBP Program beginning with FY 2019 under which value-based incentive payments are made to SNFs in a fiscal year based on performance. The incentive payments will be paid from a pool of dollars accrued through a 2 percent withhold applied to all SNFs. Based upon their rehospitalization performance, SNFs may or may not earn back the withheld 2 percent or some portion of the two percent.

Additionally, the Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185) (IMPACT Act), enacted on October 6, 2014, requires the implementation of an array of SNF quality reporting elements. Beginning with FY 2018, the Act requires SNFs that fail to submit required quality data to CMS under the SNF QRP will have their annual updates reduced by two percentage points. AHCA supported both PAMA and the IMPACT Act. The Association will continue to support quality efforts through the Association’s Quality Initiative, collaborative work with CMS, and liaison with Congress.

However, moving from volume to value payment methodologies combined with fee-for-service (FFS) payments makes it essential that the remaining FFS payments are as accurate as possible. Regarding eroding FFS payments, current nationwide Medicare Advantage (MA) enrollment is now approximately 33 percent of Medicare beneficiaries, while an additional 17 percent of Medicare beneficiaries are attributed to some form of a Medicare Accountable Care Organization (ACO). Furthermore, AHCA research indicates continued growth in MA enrollment, ACO attribution, and enrollment of duals in likely state-based Medicare-Medicaid integration programs. The end result is the volume of FFS days and related payments has significantly declined and is likely to continue to do so. Therefore, the portion of total SNF margins driven by FFS payments also has declined.

Such shifts also all require notable changes in operations, produce new costs, and typically, result in payment reductions. In light of these changes, AHCA is working with CMS’s
Medicare Advantage Business Group, the Center for Medicare and Medicaid Innovation (CMMI), the Center for Clinical Standards and Quality (CCSQ), and will continue to work with the Center for Medicare to ensure payments are accurate and ensure quality and access.

The recommendations summarized below are intended to balance the needs of providers, patients and Medicare. We believe our ideas also will help to ensure that the LTPAC sector can continue to provide critically needed services to the frail and elderly.

Recommendations
Below we offer a summary of our recommendations followed by our detailed recommendations and rationale for such recommendations.

1. **Market Basket and State Minimum Wage Laws.** AHCA/NCAL reiterates its belief that due to the rapidly changing payment environment, market basket weights and proxies should be updated as frequently as the hospitals. Additionally, CMS should take steps to address state and municipal laws which increase the minimum wage. The Association believes the Chief Actuary has the authority to take such steps at the CBSA level.

2. **Wage Index.** Over the years, AHCA/NCAL has commented many times on the need for a more accurate and appropriate approach to a SNF wage index. Last year, the Association shared a detailed approach to a SNF wage index. However, CMS continues to express concerns about the quality of SNF data. In response, AHCA/NCAL has prepared an approach this year which trims the hospital data to labor categories, better aligning with SNF categories. The Association believes this approach aligns with CMS’s preferred approach to rely upon hospital data, but offers a more accurate SNF wage index methodology.

3. **Unadjusted Per Diems.** In the proposed rule text, CMS indicates that the unadjusted per diem rates contained in Tables 2 and 3 on page 24234 were updated using the adjusted market basket rate of 2.1 percent. However, AHCA/NCAL analysis indicates the FY 2017 per diem rates must have been updated using some percentage less than 2.1 percent. We request clarification on the update percentage and methodology applied to the FY 2017 rates.

4. **Value-Based Purchasing (VBP).** AHCA/NCAL appreciates the extensive thought put into the development of the SNF VBP design, as well as CMS’s request for input on the exchange function and feedback reports to SNFs. There are four major recommendations highlighted here, but we encourage review of Section 4 containing our detailed recommendations and discussion. In addition, we conducted an extensive evaluation of the four exchange models using national SNF rehospitalization rates. We summarize the findings in our comments, and again, we encourage CMS to review the entire evaluation report available on AHCA’s website.
AHCA recommends CMS adopt a set of principles in order to determine which exchange model to utilize; this is proposed in our detailed comments below. Overall, we recommend using the logistic model, as it collectively meets the principles better than the other models. However, two features significantly impact how and which exchange models operate with respect to achieving CMS goals – creating an incentive for a wide range of rehospitalization rates and continuous improvement, as well as our suggested principles. The first feature is whether top-performing SNFs can earn back more than the 2 percent withhold (i.e., an increase in their payment rate). AHCA strongly recommends that CMS allow top-performing SNFs to receive payment adjustments that represent an increase in their SNF PPS rates (e.g. earn back more than 2 percent withhold). Capping the payment adjustment results in nearly three of the models performing similarly with approximately half of all SNFs having no incentive for further improvement. Allowing top-performing SNFs to receive an increase in payment provides a meaningful incentive.

The second feature is the size of the incentive pool. The statute allows CMS to “return” 50 to 70 percent of the 2 percent withhold. The size of the incentive pool dramatically changes how each model performs with respect to our proposed principles and CMS’s stated goal of the program. In order to create the greatest impact through the maximizing the size of the incentive, AHCA strongly believes 70 percent of the 2 percent withhold should be made available in the incentive pool.

The SNF Readmission Measure (RM) requires a minimum denominator size of 25. We recommend that the SNF VBP adjust for SNFs with a small number of beneficiaries by extending the time window on the SNF RM to two years for SNFs with fewer than 25 in the denominator. Those that remain low should be exempt from the SNF VBP payment adjustment.

5. Quality Reporting Program. AHCA has been a strong supporter of the IMPACT Act and appreciates the aggressive time frames outlined in it as to when CMS should specify the measures. These time frames should not result in incomplete or untested measures being finalized. This is why the act also requires review by the National Quality Forum (NQF) Measure Applications Partnership (MAP) and endorsement of the measures by NQF.

However, all four proposed measures are still under development and received a vote by the NQF MAP of “encourage further development,” not a vote of “support” or “support with conditions.” Also, none of these measures in their current form have undergone NQF review for endorsement, which is a requirement of the IMPACT Act. Thus, we recommend that none of these four proposed measures be finalized until they have received NQF MAP vote of “support” (or “support with conditions”) and NQF endorsement.
Furthermore, much of the feedback from the MAP for each of these measures was not addressed in the proposed rule. Two of the measures – the Medicare Spending per Beneficiary (MSPB) and the Drug Regimen Review (DRR) – do not comply with the IMPACT Act. The total cost per beneficiary does not allow a comparison across post-acute care (PAC) providers, but only a comparison between SNFs. In fact, MedPAC also highlighted this problem in its comments to CMS. The Drug Regimen Review (DRR) measure, while important, is not a medication reconciliation review measure. Since CMS continues to refine and test this measure, they should not be finalized.

In addition, since the DRR is not a required measure under the IMPACT Act, CMS does not need to meet the timelines to specify a medication reconciliation measure in the IMPACT Act. Therefore, CMS should take the time to seek NQF endorsement for the DRR before finalizing this measure in rule-making. Also, the agency should work to develop a medication reconciliation measure to satisfy the requirements of the IMPACT Act.

6. Payment Models Research. AHCA/NCAL appreciates being involved in CMS’s efforts to modernize the existing SNF PPS and agrees a number of challenges exist. These challenges should be addressed using a comprehensive SNF PPS reform approach rather than rounds of incremental changes, which may or may not produce the desired results. In the past, incremental changes – such as adding RUGs, changes to the MDS, and changes to therapy assessment schedules – have not met CMS’s goals and added administrative burden for providers. In the detailed section below, we offer a framework for PPS reform.

Conclusion
AHCA’s recommendations are based on extensive research, data analysis and feedback from members. They also reflect the real-world challenges of providing cost-effective, quality care to a growing population of individuals with increasingly complex health care needs. By working collaboratively with CMS, we believe that we can ensure development of a payment system which meets the needs of CMS, skilled nursing providers and the Medicare beneficiaries they serve. We look forward to CMS’s responses to our comments.
Section 1: Market Basket and State Minimum Wage Laws

As we commented last year, the Association remains concerned about the estimated market basket percent because of the number of adjustments and other factors which now, or will in the future, impact net SNF revenue and capacity to deliver quality care. Specifically, the base estimated market basket update percentage must be as accurate as possible because it now is subject to both the multifactor productivity (MFP) and forecast adjustments, sequestration, soon a VBP withhold, and potential quality reporting failure to report penalties that will be applied to SNF payments.

Additionally, 24 states have minimum wage laws which set the minimum wage above the federal floor. Of those, approximately half have discussions underway regarding significant increases in minimum wage laws. Below the state level, a number of municipalities have enacted minimum wage laws. At the state level, for example, California has enacted legislation raising the state minimum wage to $15 by 2020. Similar state laws are poised to be enacted in Oregon, New York and Minnesota. In these states, the minimum wage laws will be increased annually until the new wage requirement is achieved – $15 in most states and many municipalities. AHCA/NCAL strongly believes the SNF PPS annual update should account for such increases.

In terms of background, Section 1888(e)(5) of the Act requires CMS to establish a SNF market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in the covered SNF services. The SNF market basket index is used to update the federal rates on an annual basis.

While we understand CMS’s methodology for arriving at the SNF market basket, as we stated last year, we believe improvements could be made to the CMS market basket methodology and more up-to-date data used (see discussion below). Over the years, AHCA has engaged CMS in discussions on the SNF market basket. During those discussions, AHCA requested a thorough review of the CMS SNF market basket, which would include an analysis of all the weight and price proxy components of the current SNF market basket. And in the FY 2008 and FY 2014 rules, the CMS Office of the Actuary (OACT) provided detailed information on each of the proxy components and explained how they added new components.

The Association, again, asks that CMS revisit its earlier review process on the market basket and involve CMS, AHCA and other SNF organizations, as well as other appropriate government entities such as the Bureau of Labor Statistics (BLS) and any private institution in the business of creating price indices that are/might be used by CMS to develop market baskets. We hope that affected parties could pool analytical resources to collaborate on a thorough review process in light of the myriad of adjustments now made to the SNF base, estimated market basket update and related SNF payments.
Summary of AHCA Recommendations and Requests

- AHCA respectfully requests that CMS engage in an ongoing dialogue with the Association on our market basket research. The goal of such discussions is to inform CMS and support any analogous CMS effort.
- While exploring a broader market basket analysis, as outlined in the FY 2006 final Inpatient Prospective Payment System (IPPS) rule using the six weights that are derived from cost report data, CMS should use weights relative to total costs included in cost reports to update the market basket each year. Should such a process be too onerous, CMS should track these six areas every year and update every four years plus at any point in time when the aggregate percentage change of those six weights, together, changes by more than some set amount.
- CMS should explore how the Office of the Actuary could target updates to states or regions with minimum wage increases. Such increases likely would need to be made retrospectively based upon cost report data.

Detailed Discussion

We propose both a long-range and a short-range strategy for improving the market basket update methodology as well as an approach to address state minimum wage laws.

1. Longer Range, Boarder Market Basket Update Analysis

To aid CMS in examining the SNF market basket, the Association has begun reviewing the SNF market basket update methodology and its ability to accurately measure SNF cost inflation over time. This review follows a series of preliminary analyses of the behavior of the methodology with respect to the cost of providing SNF services over time. In these preliminary analyses, we observed several unusual patterns, which raise questions about whether the current market basket index methodology is the most accurate device for aligning SNF payment rates with SNF cost trends. The goal of our project is to better understand what factors from the current SNF market basket methodology are producing such unusual patterns.

In terms of our broader market basket analysis, the scope of our review project is comprised of four areas. First, we are evaluating the aggregate behavior of the methodology over time to see whether the measurement properties intended in the methodology are satisfied. Second, we are attempting to learn the econometric approaches used to calibrate and calculate the indices as well as obtain the data sources involved. It is unclear at this point whether it will be possible to obtain all of the details of what CMS’ contractor has developed. If the information is not publicly available, as part of our dialogue with CMS on this effort, we will request such information from the Agency. Third, if we are able to obtain the necessary information, we will evaluate the measurement approach as much as possible based on information included in the rule. Fourth, we will validate which of the Association’s still-under-development approaches are more precise in measuring long-run SNF cost evolution. AHCA will be conducting this project over the next year, and as noted, will engage CMS throughout the research.
2. **In the Short-Term, CMS Should Reweight the Market Basket More Frequently.**

The Congress instructed CMS to study the frequency with which a market basket should be updated in order to be most accurate, Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L.108-173, December 8, 2003, Section 404. The statute required CMS to reweight the inpatient hospital market basket immediately and to establish a set frequency for revising and reweighting the market basket. It also instructed CMS to publish an explanation of the reasons the agency chose that frequency.

The results of this study were included in the FY 2006 Inpatient Prospective Payment System (IPPS) final rule. In its analysis, CMS indicates the optimal update timeframe is every four years. However, the FY 2008 and FY2014 market basket updates were six years apart. The current market basket weights are dated, primarily from cost reports. Since the last update, SNF operations have changed significantly, driven by changes in best practice, quality efforts and SNF patient acuity. As noted above, current adjustments include the multifactor productivity (MFP) and the forecast error adjustments. Additionally, going forward, Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) added new subsections (g) and (h) to section 1888 to the Social Security Act (Act). The new Subsection 1888(h) authorizes establishing a Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program beginning with FY 2019 under which value-based incentive payments are made to SNFs in a fiscal year based on performance. The incentive payments will be paid from a pool of dollars accrued through a 2 percent withhold applied to all SNFs. Based upon their rehospitalization performance, SNFs may or may not earn back the withheld 2 percent or some portion of the 2 percent.

Additionally, the Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185) (IMPACT Act), enacted on October 6, 2014, which requires the implementation of an array of SNF quality reporting elements. Beginning with FY 2018, the Act requires SNFs that fail to submit required quality data to CMS under the SNF Quality Reporting Program will have their annual updates reduced by two percentage points. AHCA supported both PAMA and the IMPACT Act and will continue to support quality efforts through the Association’s Quality Initiative, collaborative work with CMS, and liaison with Congress.

However, moving from volume to value payment methodologies combined with eroding fee-for-service (FFS) payments make it essential that the remaining FFS payments are as accurate as possible. Regarding eroding FFS payments, current Medicare Advantage (MA) enrollment, nationwide, now is approximately 33 percent of Medicare beneficiaries while an additional 17 percent of Medicare beneficiaries are attributed to some form of a Medicare Accountable Care Organization (ACO). And, AHCA research indicates continued growth in MA enrollment, ACO attribution, and enrollment of duals in likely state-based Medicare-Medicaid integration programs.

Such shifts all incur new costs and, typically, reductions in payment. For example, on average, AHCA members report MA plans pay 15-30 percent less, and recent ACO contracts contain a myriad of quality provisions which essentially will make full payment
impossible to achieve. AHCA is working with CMS’s Medicare Advantage Business Group, the Center for Medicare and Medicaid Innovation (CMMI) and, hopefully, with the Center for Medicare to ensure payments are accurate and will ensure quality as well as access. We take this opportunity to reiterate two of our primary concerns with the current base market basket calculation and, therefore, future market basket updates which, for the foreseeable future, will be based upon the SNF PPS and its update methodology.

The weights used in calculating the market basket update should continue to use the most updated cost data available. And the market basket should be revised and reweighted with greater frequency – on the same schedule as the hospital market basket particularly if the SNF wage index continues to be directly linked to the hospital wage index (see page 18.) However, due to the rapidly changing environment described above, SNFs have made major changes in their operations, such as responding to alternative payment models, managed care, and unfolding quality requirements. The assignment of weights within the market basket does not reflect changes in SNF operations or broader marketplace changes.

The Association believes it is imperative for the market basket to be reweighted on a regular basis so that the market basket accurately reflects the type and level of expenditures in SNFs and the impact of price changes of inputs used in calculating the update actually reflect those inputs’ relative importance. We urge CMS to update the SNF market basket weights on the same schedule as hospital market basket. We believe that this will improve the validity of the SNF market basket methodology and increase the accuracy of the market basket updates.

Additionally, AHCA believes CMS has the statutory authority to implement geographically-specific updates associated with state and/or regional minimum wage laws. Such adjustments could be made at the Core-Based Statistical Area (CBSA) levels. Specifically, the statutory provisions of the Social Security Act (SSA), referenced below, appear to offer broader flexibility for adjustments than CMS’ historical practices. The Association believes the citations below support a rationale to include adjustments for geographic variations due to the enactment of significant state minimum wage laws. We do not believe the statutory authority, or limitations, of the Chief Actuary, located at 42 U.S.C. 1317(b) present an obstacle to such adjustments. The relevant SSA citations are as follows:

42 U.S.C. 1395yy(e)(4):

...  

(C) Computation of standardized per diem rate

The Secretary shall standardize the amount updated under subparagraph (B) for each facility by-
(i) adjusting for variations among facilities by area in the average facility wage level per
diem, and

(ii) adjusting for variations in case mix per diem among facilities

... 

(G) Determination of Federal rate

The Secretary shall compute for each skilled nursing facility for each fiscal year
(begning with the initial period described in subparagraph (E)(i)) an adjusted Federal
per diem rate equal to the unadjusted Federal per diem rate determined under
subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as
follows:

... 

(ii) Adjustment for geographic variations in labor costs

The Association suggests that in the short-term, state- or regionally-specific market
basket updates (e.g., at the CBSA level) could be calculated using data collected by the
U.S. Department of Labor (DOL). DOL collects minimum wage data annually, and such
information could be used to develop a rolling list of states and municipalities with
increasing minimum wage levels. Such information could also be used to flag appropriate
BLS data and link such information to cost report data from SNFs in minimum wage
states or municipalities. Subsequently, an update factor aimed at accounting for minimum
wage increases could be developed.
Section 2: Unadjusted Federal Rate Per Diems

Sections 1888(e)(4)(E)(ii)(IV) and 1888(e)(5)(i) of the Act require that the update factor used to establish the FY 2017 unadjusted federal rates be at a level equal to the market basket index percentage change. Accordingly, CMS determines the total growth from the average market basket level for the period of October 1, 2015 through September 30, 2016 to the average market basket level for the period of October 1, 2016 through September 30, 2017. This year, the process yielded a percentage change in the market basket of 2.6 percent.

In the text, CMS then discusses adjustments in the market basket percentage change by the forecast error from the most recently available FY for which there is final data and applies this adjustment whenever the difference between the forecasted and actual percentage change in the market basket exceeds a 0.5 percentage point threshold. This year no forecast error was incurred.

Section 1888(e)(5)(B)(ii) of the Act also requires CMS to reduce the market basket percentage change by the multifactor productivity (MFP) adjustment (the 10-year moving average of changes in MFP for the period ending September 30, 2017) of 0.5 percent. The resulting net SNF market basket update would equal 2.1 percent, or 2.6 percent less the 0.5 percentage point MFP adjustment. CMS goes on to note that if more recent data become available (for example, a more recent estimate of the FY 2010-based SNF market basket and/or MFP adjustment), the Agency would use such data, if appropriate, to determine the FY 2017 SNF market basket percentage change, labor-related share relative importance, forecast error adjustment, and MFP adjustment in the FY 2017 SNF PPS final rule. For FY 2016, the final market basket update was downwardly adjusted based on more up-to-date data.

In the text, CMS indicates it used the SNF market basket, modified as described above, to adjust each per diem component of the federal rates forward to reflect the change in the average prices for FY 2017 from average prices for FY 2016. Tables 2 and 3, below, display the updated components of the unadjusted federal rates for FY 2017 prior to adjustment for case-mix.

Summary of AHCA Recommendations and Requests

- CMS should revisit the FY 2017 proposed rule text to ensure the correct market basket update is noted in the narrative.
- AHCA/NCAL also believes CMS should revisit the approach to rounding applied to the unadjusted per diem rates since it appears some update less than 2.1 percent was used. Specifically, we believe the rounding factor may have been inappropriately truncated.
Detailed Discussion

Below, AHCA compares the FY 2016 unadjusted federal rate per diems with the FY 2017 unadjusted federal rate per diems. We would expect the FY 2016 rates to update by 2.1 percent, the adjusted market basket.

Figure 1—FY 2017 Unadjusted Federal Rate per Diem Urban

<table>
<thead>
<tr>
<th>Rate component</th>
<th>Nursing—Case-mix</th>
<th>Therapy—Case-mix</th>
<th>Therapy—Non-case-mix</th>
<th>Non-case-mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem Amount</td>
<td>$174.71</td>
<td>$131.61</td>
<td>$17.33</td>
<td>$89.16</td>
</tr>
</tbody>
</table>

Table 3—FY 2017 Unadjusted Federal Rate per Diem Rural

<table>
<thead>
<tr>
<th>Rate component</th>
<th>Nursing—Case-mix</th>
<th>Therapy—Case-mix</th>
<th>Therapy—Non-case-mix</th>
<th>Non-case-mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Diem Amount</td>
<td>$166.91</td>
<td>$151.74</td>
<td>$18.52</td>
<td>$90.82</td>
</tr>
</tbody>
</table>

Source: Federal Register, Vol. 79, No. 81, April 25, 2016. CMS-1645-P (page 24234)

However, if we apply a 2.1 percent increase to the FY 2016 rates, higher rates than those displayed in the FY 2017 tables are produced. First, the nursing — case mix rate urban would be increased by $3.60 totaling $175.06. The published FY 2017 rate for nursing case mix in the proposed rule is $174.71, a 35 cent difference. Second, the nursing — case mix per diem rural would increase by $3.44 (rounded from $3.4398) to $167.23, again applying 2.1 percent, a 33 cent (rounded from .3298) difference. Each of the FY 2016 rates adjusted by 2.1 percent are shown in Figure 2 below.
### Figure 2. Unadjusted Federal Rate Per Diems Applying 2.1 Percent

<table>
<thead>
<tr>
<th>Rate component</th>
<th>UNADJUSTED FEDERAL RATE PER DIEM URBAN</th>
<th>UNADJUSTED FEDERAL RATE PER DIEM RURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nursing—case-mix</td>
<td>Therapy—case-mix</td>
</tr>
<tr>
<td>Per Diem Amount</td>
<td>$175.06</td>
<td>$131.86</td>
</tr>
<tr>
<td></td>
<td>$167.23</td>
<td>$152.03</td>
</tr>
</tbody>
</table>

Analyzing the ratios among all the rates presented in the 2017 proposed rule versus the 2016 final rule rates, AHCA/NCAL believes CMS must have applied an update somewhere between 2.0680 and 2.0718 percent. We respectfully request CMS revisit the percentage noted in the narrative as well as explore whether the update factor for the FY 2017 rates was inappropriately truncated for purposes of rounding.
**Section 3: Wage Index**

Since the inception of the Medicare SNF PPS in 1998, the area wage index calculated for the hospital Inpatient Prospective Payment System (IPPS) also has been applied to the SNF PPS. Wage index values are assigned to Core-Based Statistical Areas (CBSAs) as determined by the U.S. Census Bureau and represent the hourly wage amount for all Medicare certified acute care hospitals in a designated CBSA divided by the national hourly wage amount for all Medicare certified acute care hospitals. Misstatement of an individual hospital’s data can contribute to an erroneous wage index for an entire CBSA and impact other providers, including SNFs.

Depending on the SNF’s assigned CBSA, the area wage index is applied to the labor-related portion of the SNF PPS rate, or Resource Utilization Group (RUG) rate, and added to the non-labor related portion of the rate. Since the labor-related portion of the rate is often close to 70 percent of the total RUG rate, the wage index has a significant impact on the final RUG rates for each CBSA and, of course, each SNF. An area wage index less than a 1.00 can result in a PPS rate that is below the full federal rate as published in the Federal Register and is meant to indicate that an area’s wages are lower than the national average.

AHCA has long advocated for establishment of a SNF-specific wage index based upon SNF-specific labor data from SNF cost reports. Every year, we become more convinced that use of aggregate hospital wage and benefit data is an inaccurate and inappropriate proxy for computing SNF wage indices. And over the years, the Association has repeatedly highlighted this concern. In turn, CMS has indicated SNF data is unreliable for a SNF-specific wage index and that CMS does not have the manpower to audit SNF labor data.

**Summary of AHCA/NCAL Recommendations and Requests**

- Trim hospital wage data to exclude certain job categories that do not exist in the SNF environment so it is more appropriate for developing the SNF wage index.
- Phase in implementation of the new methodology over a three- to five-year period.
- Apply a 5 percent cap to wage index fluctuations (positive or negative) during the phase-in period.

**Detailed Discussion**

This year, AHCA has developed an approach we believe aligns with CMS’s preferred approach to using hospital wage data. Specifically, we suggest trimming hospital wage data to exclude certain job categories that just do not exist in the SNF environment so it is more appropriate for developing the SNF wage index.
In terms of analysis, AHCA found that nearly 76 percent of instances in which the wage index in our “trimmed hospital data modelling” declined by more than 5 percent, it was an elevated hospital percentage of employee benefits (e.g., greater than 30 percent) in relation to wages that drove the change in the overall wage index. The Association then compared the distribution of employee benefits as a percentage of wages between hospitals (using the data in the CMS PUF) and SNFs (using data available on SNF Medicare cost reports Worksheet S-4). We found that SNF data is far more tightly clustered with very few outliers greater than 30 percent associated with benefit costs.

As a result, AHCA utilized the July 2015 CMS public use (PU) file audited acute care hospital wage data. We created two separate wage index models as part of examining alternative methods in applying alternative wage indices to the labor portion of SNF RUG rates. Each of these two separate versions included two subsets. These subsets were: 1) wage index without occupational mix adjusters and 2) with an occupational mix adjuster utilizing SNF national Bureau of Labor Statistics (BLS) data and regional health care BLS data. The application of the occupational mix adjusters is consistent between both wage index models and is outlined by “steps” in the detailed models (see below). Both models and subsets excluded categories not prevalent in SNFs (e.g. physicians, offsite clinics, private physician practices, etc.)

The first wage index model created excluded core benefits from the PU file in calculating the unadjusted wage index. This was due to the wide percentage range of benefit ratios to salaries (by CBSA) based off the PU file’s hospital data versus a more concentrated range of benefit ratios to salaries (by CBSA) for SNFs. SNF FY 2014 Healthcare Cost Report Information System (HCRIS) data based on Worksheet S-3, Pt IV benefits to Worksheet A salaries resulted in 75 percent of benefit ratios ranging from 15-25 percent. However, hospital PU file data reflected benefit ratio ranges of 15-25 percent for 32.49 percent of the CBSA population, 26-35 percent for 49.48 percent and 35 percent or more for 11.53 percent. The lowest hospital CBSA benefit ratio was 13.2 percent versus the highest at 49.82 percent. Hospital benefit ratios to salaries were determined by taking the sum of Worksheet S-3, Pt II Lines 17-25 divided by Line 1 Total Salaries for all PU file hospital providers, aggregated by CBSA.

The second wage index model includes core benefits using a ratio of PU file benefits to salaries by hospital provider. This ratio was determined by taking the sum of Worksheet S-3, Pt II Lines 17-25 divided by Line 1 Total Salaries for all PU file hospital providers, aggregated by CBSA. Each hospital’s ratio then was applied to allowable salaries for the SNF-specific wage index as defined by outlined “steps” below.

**Detailed Discussion**

Since 1997, CMS has applied a pre-floor, pre-reclassification hospital wage index (without accounting for occupation mix or outmigration) to inpatient rehabilitation facilities, inpatient psychiatric facilities, long-term care hospitals, SNFs, Hospital Outpatient Department, ambulatory surgical centers, home health agencies, and hospice facilities.
The wage index used for the SNF PPS is calculated using IPPS wage index data on the basis of the labor market area in which the acute care hospital is located, but without the following:

- Geographic reclassifications under section 1886(d)(8) and (d)(10) of the Social Security Act,
- IPPS rural floor under section 4410 of the BBA,
- imputed rural floor under 42 CFR 412.64(h), and
- Outmigration adjustment under section 1886(d)(13).1

The current area wage index methodology for adjusting Medicare payments is ripe for improvement. Specifically, the current methodology does neither appropriately nor adequately adjust Medicare payments for differences in wage rates across geographic regions for LTPAC providers. While the solutions for replacing the current system set forth by several major research institutions differ somewhat in approach, they leave no question that the current wage index is not accurate.

The deficiencies in the wage index methodology for adjusting Medicare payments have been known for many years. The issues have been identified by several leading analytic/research institutions including Medicare Payment Advisory Commission (MedPAC), Acumen LLC, RTI International, and the Institute of Medicine (IOM). These institutions have described the deficiencies with the current data and methodology, and made recommendations for systems reform.2 MedPAC and RTI research clearly delineate the key problems of the current system and recommend extensive modifications. The research conducted for CMS by Acumen, LLC, shows promise in terms of refining the area wage index itself by moving to a more market-based approach focusing on staff commuting distances. IOM work suggests numerous implementable reforms that significantly could improve the hospital wage index, as well as a wage index for various LTPAC settings.

Among many deficiencies in the current wage index, the commenters collectively found:

- Large differences in wage indices between adjoining geographic areas that have led to the establishment of numerous exceptions, which allow hospitals to be reclassified to other geographic areas.

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1 See the FY 2006 SNF PPS proposed rule, 70 Federal Register 29090 through 29092, and 79 Federal Register 25779, FY 2014, SNF PPS Proposed Rule.
• Circularity in the establishment of the wage index, whereby hospitals located in markets with few providers have the ability to set or influence the wage index for their geographic area through business practices.

• Year-to-year volatility of the wage index within a geographic area that does not appear to be related to underlying changes in local labor market conditions.

• A hospital wage index that is not geographically representative of other types of facilities such as home health agencies and SNFs. Stated another way, facilities other than short term acute care hospitals may be located in areas where there are no short-term acute care hospitals.

• The use of only IPPS hospital wages to calculate a wage index for nonmetropolitan areas in which most employees work at smaller establishments does not accurately reflect the type of labor that facilities other than short-term acute care hospitals provide or the wages that they pay.

The commenters examined and analyzed massive amounts of data in their efforts to develop the best approaches to a new and very much improved wage index. The Association believes it is notable that MedPAC, Acumen, and IOM all found that a system based solely on hospital labor cost data is inappropriate.

The problems inherent in the current wage index methodology ignore basic guiding principles developed by the above institutions in their quest for wage index reform. These system fairness principles require that such a system should, for example be:

• Theoretically sound.

• Seen as fair by providers in other sectors as well as by hospitals.

• Less volatile year to year.

• Implemented so that large changes in wage index values are phased in over a transition period.

• A system that does not require reclassifications and a myriad of other adjustments that favor one provider over another and one provider sector over another and fail to improve the application of the wage index.

**Modified Hospital Wage Index Approach.** Area wage indices are based on labor data reported on the hospital Medicare Cost Report, Worksheet S-3 Part II and III. While similar data is reported on the SNF Medicare Cost Report, CMS has long maintained that the hospital data is more reliable, in part because it has been audited by Medicare contractors for many years. Despite being provided evidence that SNF wage data as reported on the SNF Medicare Cost Report is no less variable than the hospital data, CMS continues to resist developing a SNF specific index citing the additional audit resources that would be required.

The expansion of hospital services in response to health care reform, including the acquisition of physician practices, has made the use of the hospital wage index in the SNF PPS even more problematic and volatile. Some acquired practices are considered
hospital-based and are included in the wage index, while others are not. In instances where the clinics are included, it is often only the non-physician employees whose wage and benefits information is reported, thereby eroding the relative wage for the hospital to the national average.

Further, there are provisions within hospital regulations that allow hospitals to reclassify to another area for purposes of the wage index and limit the application of wage indices to payment rates when they are below the rural index of the state. No such relief is afforded SNFs. This issue, when combined with the issue of acquired physician practices, seems like a double penalty because the provider that caused the wage index decline was able to escape its effect while leaving all the other providers to deal with the implications.

Given these inequities, AHCA urges CMS explore the development of an alternative SNF wage index. Specifically, AHCA suggests that CMS develop a SNF wage index based on the portion of the hospital staffing and labor data that are similar for both hospitals and nursing facilities, while removing labor data that is specific to hospitals, only. The resulting index could be further tailored to SNFs by weighting it by publicly available occupational mix data for SNFs published by the Bureau of Labor Statistics (BLS).

AHCA/NCAL undertook the following steps to model this approach:

1. Using the latest available final wage index Public Use File (PUF) posted on the CMS website which contains wage data from more than 3,400 acute care hospitals, AHCA removed the dollars and hours related to positions that are mostly applicable to hospitals. These include physicians, CRNAs, interns & residents and other teaching physician costs, and excluded or non-reimbursable cost centers not normally present in skilled nursing facilities. The related portion of fringe benefits and overhead was also removed.

2. Using the formula and processes established by CMS and delineated in the Federal Register, AHCA calculated the SNF-specific wage index for each CBSA based on the above modified data. These indices were compared to the current computation using all hospital data.

3. AHCA then “weighted” each CBSA’s SNF specific wage index by BLS occupational mix data for nursing facilities. The resulting wage indices were again compared to the methodology currently used for computing SNF wage indices.

Two Possible Options. CMS should modify use of hospital wage index data to better align with SNF labor costs. We offer two approaches, one with occupational mix and one without. The Association requests CMS’ reaction to both possible approaches.

Option 1 – Alternative Method for Computing the Unadjusted Acute Care Hospital (IPPS hospitals) Wage Index to be Applied to Skilled Nursing Facility (SNF) Without
an Occupational Mix Adjustment Factor. The alternative method used to compute the unadjusted IPPS hospitals' wage index, without an occupational mix adjustment factor, to be applied to the labor portion of the SNF RUGs’ published rates follows:

- **Step 1** – Use the audited IPPS hospital wage and hour data from Worksheet S-3, Parts II and III of the Medicare cost report (contained in the CMS Public Use file) to arrive at an alternative method in applying the wage index to SNF RUG rates. Using the audited IPPS hospital data from Worksheet S-3, Parts II and III of the Medicare cost report, an alternative method will be used to calculate the unadjusted wage index to be applied to the labor portion of the SNF RUGs’ published rates beginning October 1 of each federal fiscal year.

- **Step 2** – Exclude cost centers more prevalent in IPPS hospitals versus SNFs from the wage index calculation. The method of calculating the unadjusted wage index excludes non-reimbursable cost centers (freestanding clinics and physician private practices), Part A and Part B physicians, Interns & Residents, and the overhead cost centers Cafeteria, Central Services & Supply and Pharmacy. Additional exclusions comprise of core benefits as outlined at Step 3 and home office which differs between IPPS hospitals and SNFs and whose wages and benefits are allocated between direct reimbursable, non-reimbursable and overhead cost centers in arriving at the IPPS hospital wage index.

- **Step 3** – Using hospital data from the PU File, calculate an overhead factor, excluding Cafeteria, Central Services & Supply and Pharmacy to be applied to direct reimbursable salaries. Calculate overhead salaries excluding Cafeteria, Central Services & Supply and Pharmacy (Step 2) by first subtracting Worksheet S-3, Pt II Salaries on Lines 36, 39 and 40 from Worksheet S-3, Pt III Total Overhead Cost Salaries on Line 7. Next, arrive at adjusted total salaries less Cafeteria, Central Services & Supply and Pharmacy by subtracting aforementioned excluded overhead salaries from S-3, Pt II Line 1 Total Salaries. Adjusted overhead salaries (adjusted Worksheet S-3, Pt III Total Overhead Cost Salaries on Line 7) divided by adjusted total salaries (adjusted Worksheet S-3, Pt I Total Salaries on Line 1) equals the overhead factor to be applied to direct reimbursable salaries at the following steps.

- **Step 4** – Using hospital data from the PU File, calculate direct reimbursable salaries, excluding overhead and Physician Part A, for which the overhead factor (Step 3) will be applied. Calculate direct reimbursable salaries excluding overhead (factor to be applied per Step 3) and Physician Part A Salaries. Using Worksheet S-3, Pt III, Line 3 Subtotal Salaries, subtract S-3, Pt II Lines 36, 39 & 40 (excluded overhead per Step 3). This results in reimbursable salaries per the unadjusted hospital wage index and includes applicable overhead and Physician Part A salaries. Next, subtract adjusted overhead calculated at Step 3 (Worksheet
S-3, Pt III Total Overhead Cost Salaries on Line 7 less Worksheet S-3, Pt II Lines 36, 39 and 40 Cafeteria, Central Services & Supply and Pharmacy Salaries) and Worksheet S-3, Pt II, Line 4 Physician Part A salaries. This results in direct reimbursable salaries less overhead and Physician Part A salaries.

- **Step 5** – Apply the calculated overhead factor to direct reimbursable salaries to arrive at adjusted reimbursable salaries including overhead. Using the overhead factor calculated at Step 3, multiply this factor + 1.0 to calculated direct reimbursable salaries at salaries for each IPPS hospital in the CMS PU File.

- **Step 6** – Using hospital data from the PU File, calculate a benefit factor to be applied to calculated direct reimbursable salaries and applicable overhead at Step 5. Calculate a benefit factor by summing core-related benefits from Worksheet S-3, Pt II Lines 17 - 25 and dividing this amount by Total Salaries (adjusted) at Worksheet S-3, Pt II Line 1.

- **Step 7** – Multiply the benefit factor at Step 6 (plus 1.0) times the direct reimbursable salaries and calculated overhead at Step 5 to arrive at adjusted salaries plus benefits by hospital.

- **Step 8** – Arrive at the contracted patient care wages using Worksheet S-3, Pt II, Line 11.

- **Step 9** – As a result of Steps 7 and 8, arrive at calculated reimbursable wages, prior to adjustments for the midpoint and partial year hospitals included in the PU File. Calculated reimbursable salaries and wages, adjusted for benefits as described at Step 6, are the result of adding direct reimbursable salaries from Step 7 and contracted patient care wages from Step 9. These wage amounts are subsequently adjusted for the midpoint and for partial year cost reporting periods contained in the CMS PU File.

- **Step 10** – Compute direct reimbursable, overhead (factor) and contracted patient care hours following Steps 4 through 8.

- **Step 11** – The result of Step 9 divided by Step 10 is the unadjusted salary and wage rate by IPPS hospital provider.

- **Step 12** – Using Step 5 through Step 9 as outlined in the August 18, 2011 Federal Register (final IPPS rule), calculate the midpoint and alternative wage
index, by CBSA, as the result of preceding Steps 3 through 10.

**Option 2 – Alternative Wage Index Application Steps for SNFs – Occupational Mix Adjusted.** Alternative Method for Computing the Unadjusted Acute Care Hospital (IPPS hospitals) Wage Index to be Applied to Skilled Nursing Facility (SNF) Resource Utilization Group (RUGs) published rates which includes regional CBSA occupational wage mix (OWM) factors. Occupational wage mix factors are applied only to the wage portion of the wage index.

- **Step 1** – Using Bureau of Labor and Statistics (BLS) data, arrive at the national SNF Hourly Mean Wage rates and Employment Statistics to be applied to the regional Core-Based Statistical Area (CBSA) occupational wage mix. Using selected periodical BLS data, arrive at listed nursing and therapist employment statistics and hourly mean wage rates by category. Next, list total occupational SNF employment statistical data which encompasses nursing, therapists and all other SNF category employment statistics. Finally, compute the national SNF occupational wage mix ratios by category using employment statistics by category as the numerator.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Employment Stat</th>
<th>Hourly Mean Wage</th>
<th>SNF OWM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapists (291122)</td>
<td>11,420</td>
<td>$42.63</td>
<td>0.69%</td>
</tr>
<tr>
<td>Physical Therapists (291123)</td>
<td>13,220</td>
<td>$43.98</td>
<td>0.80%</td>
</tr>
<tr>
<td>Respiratory Therapists (291126)</td>
<td>5,010</td>
<td>$28.94</td>
<td>0.30%</td>
</tr>
<tr>
<td>Speech Language Pathologists (291127)</td>
<td>5,770</td>
<td>$44.02</td>
<td>0.35%</td>
</tr>
<tr>
<td>Registered Nurses (291141)</td>
<td>154,060</td>
<td>$30.53</td>
<td>9.32%</td>
</tr>
<tr>
<td>Licensed Practical and Licensed Vocational Nurses (292061)</td>
<td>212,980</td>
<td>$21.66</td>
<td>12.88%</td>
</tr>
<tr>
<td>Nursing Assistants (311014)</td>
<td>612,120</td>
<td>$12.36</td>
<td>37.02%</td>
</tr>
<tr>
<td><strong>All Occupations</strong></td>
<td><strong>1,653,320</strong></td>
<td></td>
<td><strong>61.37%</strong></td>
</tr>
</tbody>
</table>

- **Step 2** – Using BLS published data, obtain health care CBSA wage rates for nursing and therapists by category and CBSA. Using the same SNF assigned occupational wage codes, regional (CBSA) “mean” wage rates were retrieved from published BLS data under categories 29-0000 Healthcare Practitioners and Technical Occupations and 31-0000 Healthcare Support Occupations. These wage rates were posted for each nursing and therapists' category by CBSA.

- **Step 3** – Using the results of Steps 1 and 2, calculate the occupational mix adjustment factors for nursing and therapists' categories and by CBSA. Using the BLS data obtained at Steps 1 and 2, calculate the occupational mix adjustment factors for the nursing and therapists' categories by dividing the
national SNF mean rates (numerator) by regional CBSA health care mean rates (denominator) by category.

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses (291141)</td>
<td>12580</td>
<td>$30.53</td>
<td>$35.45</td>
<td>86.12%</td>
<td>$254,663,701</td>
</tr>
</tbody>
</table>

- **Step 4** – Obtain the unadjusted wage index by CBSA for which the occupational mix adjustment factors will be applied. The unadjusted wage index amounts by CBSA are dependent on the methods used to calculate the wage index (CMS or alternative methods). This wage index has been adjusted for the midpoint and any partial reporting periods included in the CMS PU File.

- **Step 5** – Calculate the occupational wage mix salaries by nursing and therapist's categories and CBSA. Calculate the occupational wage mix salaries by nursing and therapists’ categories by multiplying the unadjusted wage index in Step 4 by the category mix adjustment factor in Step 3 and then by the BLS SNF national percentage of occupation category to total SNF in Step 1. This calculation is to be completed for each nursing and therapists' category and summed to arrive at the aggregate nursing and therapists' occupational wage mix adjusted wages by CBSA.

<table>
<thead>
<tr>
<th>Example:</th>
<th>CBSA</th>
<th>Sample Unadjusted Wage Index</th>
<th>Category Mix Adjustment Factor</th>
<th>SNF Nat’l Occupational Mix OWM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses (291141)</td>
<td>12580</td>
<td>$3,172,832,259</td>
<td>86.12%</td>
<td>9.32%</td>
</tr>
</tbody>
</table>

- **Step 6** – Calculate all other occupational mix categories (non-nursing and non-therapists) to be added to the nursing and therapists' occupational wage mix amounts calculated at Step 5. Using the BLS SNF national labor statistic data, arrive at a percentage of all other categories employment statistics by subtracting the sum of the nursing and therapists' category employment statistic ratios from 100 percent. This will result in an all other occupational category employment statistical ratio to be multiplied times the unadjusted wage index amounts at Step 4 to arrive at the all other occupational wage mix adjusted wages.

- **Step 7** – Arrive at calculated occupational wage mix adjusted wages by CBSA as a result of the nursing and therapists' wage mix adjusted wages (Step 5) and the all other category occupational wage mix adjusted wages (Step 6).

- **Step 8** – Obtain the unadjusted wage index hours from the unadjusted wage index amounts by CBSA referred to at Step 4.
• *Step 9* – The occupational wage mix adjusted rates by CBSA divided by the aggregate occupational wage mix rates resulted in OWM adjusted wage indices.
Section 4: SNF Value-Based Purchasing Program

NOTE: This section is organized by each heading in the SNF NPRM for the section A: Skilled Nursing Facility Value Based Purchasing (VBP). After each heading, we briefly summarize CMS’s proposal, which is followed by AHCA’s recommendations and supporting discussion. In addition, AHCA has undertaken extensive evaluation and testing of the four different exchange models using national data on rehospitalization rates for all Medicare and Medicaid certified facilities. A detailed report with the impact of each model is available on AHCA’s website. We only include a summary of our findings in this section but encourage a review of the report for the detailed analysis supporting our recommendations.

A. Skilled Nursing Facility Value-based Purchasing (SNF VBP)

CMS seeks comment on how to operationalize SNF VBP program specified in the PAMA Act of 2014. CMS proposes a new rehospitalization measure – SNF Potentially Preventable Rehospitalization (PPR), how to calculate the rehospitalization score, and an exchange function to determine a SNF’s Part A payment adjustment.

A1. Background – No comments

A2. Measures

a. SNF RM (NQF # 2510) – No comments

b. Measure SNF PPR

CMS proposes a potentially preventable rehospitalization measure, the SNF PPR. It is based off of (e.g. “harmonized with”) the SNF RM measure finalized in last year’s rule. The SNF PPR is a risk-adjusted measure based on Part A claims, and thereby measures only individuals in the Medicare FFS program and does not count readmissions classified as observation status, since observation stays are covered under Part B. The measure excludes elective readmissions and only counts readmission that have a readmitting primary diagnoses that is considered potentially preventable. CMS defines potentially preventable as “a readmission for which the probability of occurrence could be minimized with adequately planned, explained and implemented post-discharge instructions, including the establishment of appropriate follow-up ambulatory care.” The risk adjustment calculates a “predicted actual” readmission rate compared to the “expected readmission rate” and multiplies the ratio by the national average readmission rate.

AHCA Detailed Recommendations:

1. CMS should not finalize the measure, as the full measure specifications are not provide to allow adequate public comment.
The link provided for the measure specifications takes one to CMS’ web page on SNF VBP, which has a link to technical 731-page report. It was not available for the Technical Expert Panel (TEP) or National Quality Forum (NQF) Measure Applications Partnership (MAP) to review prior to posting of SNF NPRM. The risk adjustment model is new. While we appreciate the time pressures CMS is under to specify the measure by October 1, 2016, we do not believe the proposed measure that will impact Medicare beneficiary access to and delivery of care as well as SNF payment should be rushed to meet an artificial deadline. In fact, Congress indicated that the measure should be used “as soon as practicable” – not as soon as possible. This is also consistent with the recommendation by the NQF MAP; see next recommendation.

2. **CMS should not finalize this measure, as the NQF MAP only voted to recommend this measure as “encourage further development.”** NQF MAP did not vote to “support” or “support with conditions.” CMS should submit this measure for NQF endorsement as specified in the PAMA Act.

The measure was not finalized and was still under development when presented for public comment and to the NQF MAP. CMS acknowledged as much in the SNF NPRM: “at the time, the risk adjustment model was still under development.” Given the NQF MAP recommendation to CMS to “continue further development” for this measure, the SNF PPR should not be finalized but resubmitted to the NQF MAP as a fully developed measure once it has received NQF endorsement. While the SNF VBP statute require CMS to specify a SNF PPR by October 1, 2016, the statute states that CMS should adopt this measure “as soon as practicable.” While the act does specify that NQF endorsement may be optional (“The application of the provisions of section 1890A shall be optional in the case of a measure specified under paragraph (1) and a measure specified under paragraph (2)”), Congress indicated that the adoption of a SNF PPR measure should be “as soon as practicable.” We believe measures to be used for payment that will have a significant impact beneficiary access and quality, as well as on providers, should undergo consensus review as specified under IMPACT Act.

3. **CMS should wait until the SNF PPR is fully endorsed by NQF before switching from the SNF RM measure to the SNF PPR measure.**

CMS seeks comment on when the SNF VBP program should transition from the SNF RM measure to the SNF PPR measure. Given that the statute indicates as soon as practicable (it does not say as soon as possible), AHCA would support transitioning once the SNF PPR receives unconditional endorsement from the NQF – but in any scenario, at least two years after SNF RM measure has been used in the SNF VBP program. A more rapid transition will cause confusion to providers just learning to understand the new SNF RM measure.

4. **CMS should use an “actual readmission rate” to calculate the standardized Risk Ratio (SSR) rather than predicted, or show empirically how a “predicted
actual” results in significant different rankings of SNFs to justify this more complicated and less easy to understand methodology.

CMS states that the numerator of the measure “does not have a simple form for the numerator – that is, the risk adjustment method does not make the observed number of readmissions the numerator.” Rather the “numerator is specifically defined as the risk-adjusted estimate” or in the technical manual as “mathematically related to the number of residents in the target population who have the event of a potentially preventable, unplanned readmission (PPR definitions and planned readmissions are described below) during the readmission window (i.e. 30 days post prior hospital discharge).” AHCA understands the statistical rationale for using the risk-adjusted estimate versus actual readmission rate in the SSR, but does not believe that this approach provides superior or more accurate information than just the actual admission rate. In fact, it will provide more confusing information. It is not easy for providers to understand or replicate. It will not match their own actual rates leading to more appeals for inaccurate data, questioning the accuracy of the data and making it less likely to be used the data as part of their quality improvement efforts. CMS should show the use of predicted actual results in different rankings (the rates will differ between the two methods). But, the rankings – which matter in this program and in public reporting programs – is unlikely to differ. If there is not a great difference between methods, we would recommend using the simpler of the two methods. The principle of picking a simpler method is provided by CMS in several arguments elsewhere in the SNF NPRM. We would argue the same logic should apply to the decision to choose a “predicted actual” or “actual” readmission rate in the SSR.

5. The risk adjustment variables should include functional and cognitive status.

Functional and cognitive status are one of the strongest predictors of future health care utilization. Currently, the risk adjustment is limited to demographic, diagnosis and procedure codes from claims. No functional or symptoms are included. The MDS contains a wealth of information on functional and cognitive status. With the purpose of the IMPACT Act to create standardized assessment instruments and PAC measures, we believe the IMPACT measures risk adjustment needs to include such variables. All the PAC instruments contain such information, albeit using slightly different assessments until later this year when CMS mandates the use of section GG for functional assessment and later for cognitive assessment. The variations in the ADL assessment tools used in the different PAC settings should not restrict their use in risk adjustment. It is better to include them in risk adjustment even though they differ than to leave out the information all together.

6. The exclusions should not exclude individuals who died during the SNF stay.

CMS proposes to exclude individuals who die during the SNF stay from the SNF PPR. However, individuals who die could still have been hospitalized for
a PPR prior to dying. The logic that those who die do not have a post discharge period to observe is a true statement, but it does not mean they should be excluded from the SNF PPR (which includes readmission during the SNF stay as well). Thus, these individuals could have been hospitalized prior to dying. By excluding them, CMS will overestimate readmission rates in SNFs with high rates within SNF stay mortality, thus using CMS logic for why the SNF VBP readmission measure should include readmission after discharged. This creates an incentive to let people die in the SNF rather than send them to the hospital and avoid counting them in this measure. We don’t believe this hypothesis is true or providers will do such a thing, just as much as they will discharge sick residents home to be hospitalized from there so they don’t count in the measure. But if CMS is to be internally consistent in their logic, residents who die during their SNF stay should not be excluded.

7. The SNF PPR should be harmonized with the other PAC PPR measures, which are within stay measures, and only count PPR readmissions that occur during the SNF stay. This is consistent with the NAF MAP recommendation as well.

The SNF PPR proposed measure will be the only PAC PPR that counts readmissions during a person’s stay and after discharge. The QNF MAP recommended “a change in specifications to be 'within' SNF stay to align with other measures and avoid duplication of readmission metrics. Specifically, the MAP suggested this measure be reviewed for actionability and accountability and to consider the breadth of measures focused on readmission and encourage alignment.” The SNF PPR will also double count readmission measures with the SNF QRP potentially preventable readmission measure post SNF discharge. CMS states concern that not counting PPR after SNF discharge may incentivize SNFs to prematurely discharge individuals home so they will be hospitalized from there rather than count in this measure. This unproven hypothesis can be monitored by the SNF QRP proposed measure, and CMS has numerous other programs – including the SNF Requirements of Participation enforcement, the Five-Star ratings, public reporting on Nursing Home Compare and Medicare payment audits – to monitor and penalize SNFs found to behave in such a manner. The SNF VBP statute neither requires nor specify that the SNF VBP program measure must include readmissions following SNF discharge. In fact, the language of the statute implies the program should focus on readmissions during the SNF stay. The IMPACT Act was written after the PAMA Act containing the SNF VBP and focused on PPR measures after discharge, which implies Congress was concerned about measure readmissions after discharge not covered in the early passed PAMA. If CMS continues to discount this argument, then only PPR readmissions that occur within seven days of discharge should be included following the logic put forth by CMS to address concern about early discharges home. This is because early discharges home may manifest themselves with higher ER use and hospital admissions within the first seven days. Readmissions after that are reflective of the quality and access to ambulatory care.
8. **AHCA supports a minimum denominator size of 25, as specified in the technical manual, but prefers 30.** This will yield less variability from the randomness of patients admitted during the year, despite risk adjustment. Also see comments on minimum denominator size for use in the SNF VBP rehospitalization score calculations.

CMS typically uses a minimum denominator size of 20 for short-stay measures or 30 for long-stay measures for quality measures on Nursing Home Compare. Quality measure analyses (e.g. bootstrap analyses) will show that the variability in measure for a single provider starts to increase when the denominator size drops below 50 and significantly increases after 30 increasing to unacceptable levels at 20. Thus, smaller SNFs with less than 30 Medicare FFS admissions a year can result in large year to year variation in their rates and large variation in the randomness of patients admitted to their SNF. This variability increases significantly between 30 and 20. While 25 is better than 20, we believe 30 should be used as the minimum denominator size for the SNF PPR. Given that the SNF PPR will be used in the SNF VBP to adjust payment rates up to 2 percent for an entire year, we would recommend CMS at least show the data on how much variation occurs between SNF PPR rates when minimum denominator size of 25 versus 30 are used. We also recommend that for SNFs with small denominator sizes (less than 25), they have the measure time window expanded from 12 months to 24 months to increase the denominator and their participation in the SNF VBP program.

9. **AHCA recommends that CMS use language when describing the measure and justification consistent with the definition that these readmissions are potentially preventable, not preventable.**

The literature demonstrates that many of these admissions still occur even with ideal care consistent with all standards of practice and the last guidelines. We agree that they are potentially preventable and support that terminology. However, CMS uses terms to justify the diagnoses selected as “should be avoidable” rather than “may be avoidable.” Terminology justifying the diagnoses that counts as PPR, repeatedly referred to “inadequate management” (i.e. “inadequate management of chronic conditions,” “inadequate management of infections,” and “inadequate management of other unplanned events.”) Also, in estimating the cost savings, CMS assumes or cites literature that assumes 100 percent of the readmissions were preventable. This is inconsistent with the definition and literature on potentially preventable readmissions, and it provides misleading information on the potential impact this measure may have on practices. The original measure, developed by AHRQ and that served as the basis for this measure per the background, was to assess the availability and access to services in a community and measured readmission rates in a community not by individual providers. However, this measure has been extended to individual hospitals and then other providers. Again, this is not an unreasonable idea, but the language and measure construction needs to be modified to account for the
use measuring individual providers rather than the access to services in a community at large. The language used by CMS in the NPRM also implies that the goal of this measure should be zero. A SNF PPR rate of zero in many facilities, particularly in facilities with larger volume of short stay residents, can only be achieved by denying hospital services to needed individuals. We do not believe that is CMS’s intent with the use of this measure. The context and description of this measure will be important in how the providers, consumers and policymakers interpret and respond to the results of this measure.

10. Please provide the reference to footnote 21 on page 24245. Footnote 20 is listed at the bottom of the page and the next footnote on page 24248 is 22.

A3. Performance Standards
a. Background – No comments
b. Proposed performance standards calculation methodology

CMS states “that an essential goal of the SNF VBP program is to provide incentives for all SNFs to improve the quality of care that they furnish to their residents.”

AHCA Detailed Recommendations:
- CMS needs to recognize that at some point further incentivizing improvement for top performers may be harmful to patients.

While conceptually this seems an attractive goal for many measures, including the SNF RM measure, an incentive to further lower the rehospitalization rate may be harmful. It creates an incentive to not send individuals to a hospital who require it. Also, at some point, putting further resources into measures with high performance is not efficient resource allocation. As pointed out by CMS in prior rules, once high achievement on quality measures are achieved, the measures should be dropped or changed. Most measures are not perfect, making a perfect score rarely zero or 100 (depending on the measure construction). To incentivize achieving perfect rates (e.g. zero or 100 percent on a measure) could be harmful to beneficiaries.

(1) Proposed achievement performance standard and benchmark

CMS proposes to the 25th percentile of national SNF performance on the quality measure during the applicable baseline period, but seeks comment on using either the 10th or 50th percentile. CMS further proposes to use the same methodology in the hospital based VBP program to define the benchmark rate. CMS propose to “define the ‘benchmark’ for quality measures specified under the SNF VBP program as the mean of the top decile of SNF performance on the quality measure during the applicable baseline period.”
AHCA Detailed Recommendations:

- **AHCA supports using the 25th percentile of national SNF performance on the quality measures during the baseline period and no other percentiles discussed by CMS.**

  AHCA agrees with CMS rational for proposing the 25th percentile and has concerns about using 15th and 50th percentile. The 25th percentile already will result in nearly 20 percent of SNFs with the lowest scores receiving a full payment adjustment equivalent to a significant 2 percent cut. By increasing the percentile, the lowest performing SNFs will have a much higher hill to climb to avoid any payment adjustment, which would be discouraging. Despite improvement, they still see a significant downward payment adjustment. Using a larger percentile that increases the number of SNFs receive such a cut would be contrary to the CMS goal to create an incentive to improve. We believe the 25th percentile can still create higher incentive payments to top performers based on the exchange structure.

- **AHCA supports the proposed methodology for defining the benchmark as the mean of the top decile.**

(2) **Proposed Improvement performance Standard**

CMS proposes to define the ‘improvement threshold’ for quality measures specified under the SNF VBP program as each specific SNF’s performance on the specified measure during the applicable baseline period, which is two calendar years prior to the performance period.

**AHCA Detailed Recommendations:**

- **AHCA supports the definition proposed by CMS on creating an “improvement threshold.”**

(3) **Publication of Performance Standard Values**

CMS proposes to publish these numerical values no later than 60 days prior to the beginning of the performance period but, if necessary, outside of notice-and-comment rulemaking.

**AHCA Detailed Recommendations:**

- **AHCA supports the proposed timing and method for publishing SNFs numerical values and payment adjustments.**

AHCA appreciates the complexity of calculating the rehospitalization score and CMS’ efforts to have the performance period as close to the payment adjustment period. In doing this, we understand that the CMS may need to publish SNF’s payment adjustment and values outside the normal SNF NPRM dates. We believe this is a reasonable trade-off to have the performance period as close to the payment adjustment as possible.
A4. FY 2019 Performance Period and Baseline Period

a. Background – No comment

b. Proposed FY 2019 Performance Period

CMS proposes to “adopt calendar year (CY) 2017 (January 1, 2017 through December 31, 2017) as the performance period for the FY 2019 SNF VBP Program, with a 90-day run out period immediately thereafter for claims processing.”

AHCA Detailed Recommendations:

- AHCA supports using CY for the performance period and CY 2017 as the first performance period for payment adjustment in FY 2019.

  We appreciate the effort by CMS to make the performance period as close to the payment adjustment and support using a CY (rather than FY or some other time frame) and CY 2017 as the first performance period.

c. Proposed FY 2019 Baseline Period

CMS proposes using a baseline period based on a CY and two years prior to the performance period. Therefore, CMS is proposing to use CY 2015 (Jan 1, 2015 to Dec 31st 2015) for the baseline period.

AHCA Detailed Recommendations:

- AHCA supports CMS proposal to base the baseline period on CY two years prior to the performance period.

A5. Proposed SNF VBP Performance Scoring

a. Background – No comment

b. Proposed SNF VBP Program Scoring Methodology

CMS proposed to use a 0 to 100 points for performance score and 0 to 90 for improvement score using the 25th percentile on national baseline period to set the achievement minimum score.

AHCA Detailed Recommendations:

- AHCA supports the proposed approach for the scoring methodology.

  While the proposed approach is complicated, we believe it is a reasonable approach and appropriately awards improvement and achievement in a manner that improvement cannot exceed achievement, a principle many of our members raised last year in our comments.

  - AHCA supports using the 25th percentile from national baseline period.

We agree with CMS rationale why the SNF VBP program differs from the hospital program, such that setting the 50th percentile as done in the hospital VBP would be inappropriate for the SNF VBP. Using the 25th percentile, we estimate
approximately 18 percent of SNFs will receive a score of zero (after factoring in improvement), which is a significant number of SNFs. Setting a higher percentile would unfairly make the lowest performing SNFs unable to avoid a full 2 percent cut in their payment rates.

(1) Proposed scoring of SNF performance on SNF RM

CMS proposes to calculate the inverse rehospitalization rate so that a higher number represents better performance. CMS believes the concept that a lower number represents better performance, which will be confusing to providers and consumers.

AHCA Detailed Recommendations:

- AHCA appreciates CMS’s approach and does not feel it matters whether one needs to calculate the inverse or not.

Most quality measures that SNF providers receive from CMS and that are publicly reported on CMS Nursing Home Compare all take the same form as the SNF RM, meaning a lower number represents better performance. Thus, providers and consumers are used to this logic. However, given the requirement of the SNF VBP to rank order SNFs on their rehospitalization score and link that ranking to payment adjustment, we can appreciate CMS’ desire to transform rehospitalization rates so that higher numbers represent higher performance. So, while it makes the calculated algorithms a bit more complicated, we can understand the Agency’s approach and do not take a position on this.

- To calculate performance scores, AHCA recommends CMS uses the standard 12-month widow to calculate the SNF-RM for SNFs meeting the minimum denominator size of 25. For those with smaller denominator size, CMS expand the time window to 24 months to increase the number of SNFs with small volume of Medicare admissions to participate in the program. For SNFs that still have a small denominator (less than 25), we recommend CMS exempts any SNFs with fewer than 25 stays in the two-year period from the SNF VBP policy (i.e., they are paid 100 percent of their usual SNF-PPS rate).

The SNF RM is calculated over a 12-month window and has a minimum denominator size of 25 as per the NQF endorsement of the SNF RM. We believe that CMS can straightforwardly construct a two-year version of the SNFRM as the volume-weighted mean of two consecutive years of SNFRM rates without applying the denominator minima, and then applying the denominator minimum after the fact. This would of course also change the baseline widow of time to two years as well. For these SNFs, we recommend that no interval between the baseline and performance period be provided.

The exemption of SNFs with low denominator sizes will be, by definition, insignificant. AHCA analysis of the SNF PPS stays associated with the new Nursing Home Compare rehospitalization measure, whose denominator definition, though with a slightly lower denominator minimum of 20, shows that around 7.4 percent of SNFs and 1 percent of stays would be excluded. Expanding
the denominator minimum by 25 percent would probably increase the SNFs excluded to around 9.2 percent and Medicare stays excluded to around 1.6 percent, based on the rough assumption that the facility distribution is uniform over SNFs with 1-25 stays. Similarly, if one were to use the two-year SNFRM for those with fewer than 25 stays in the one-year SNFRM, then the remaining SNFs excluded would be approximately 4.8 percent, and they are associated with around 0.4 percent of all Medicare stays each year.

The exemptions of the remaining 4.8 percent of SNFs associated with just 0.4 percent of all Medicare stays each year is justifiable given these providers are likely serving isolated areas or providing specialist services. Paying them 100 percent of their base SNF-PPS rate (i.e., none of the 2 percent withhold is applied) is consistent with the goal of preserving access to post-acute services to patients in isolated areas or needing specialist services.

Including small denominator size SNFs in the SNF VBP will also cause problems to other SNFs. Small denominator size SNFs will have their SNF RM rates bounce around due both to variability in types of admissions and the increments associated with each readmission. Thus, including these SNFs can inappropriately change other larger SNFs ranking and therefore payment rates – not because of differences in care but because of random differences in patients.

(2) Scoring SNF Performance Based on Achievement

CMS proposes to set the performance rate of zero points at the national 25th percentile and 100 points at the benchmark, which is the mean of the top decile. The points between 0 and 100 are distributed between these rates using a proposed formula that evenly distributes points for rates between the 25th percentile and benchmark rates.

AHCA Detailed Recommendations:

- AHCA supports the approach proposed by CMS for the initial years of the program but needs to monitor the rates over time and if the differences between the 0 and 100 point thresholds are meaningful.

  At some point as SNFs improve, the points may not reflect meaningful differences, particularly at the top end of the scale and may create an incentive to continue to lower a rehospitalization rate that may not be clinical or safely possible.

(3) Scoring SNF Performance based on Improvement

CMS proposes to set improvement score range of 0 to 90. Zero points would be for SNFs with no improvement between the baseline and performance periods. Ninety points would be the national benchmark rate. The remaining points would be based on “unique improvement range established for each SNF that defines the distance between the SNF’s baseline period score and the national benchmark for
the measure (which CMS propose to define as the mean of the top decile of SNF performance on the measure during the baseline period).

**AHCA Detailed Recommendations:**

- **AHCA supports the proposed logic and algorithm for calculating a SNF’s improvement score.**

  AHCA is appreciative that the proposed method takes into consideration that improvement score cannot trump a SNF with a better achievement than a SNF with very high improvement but whose performance rate is still worse than a SNF with higher performance. Including improvement score creates a strong incentive for all SNFs to improve and helps recognize SNFs with lower performance at baseline an opportunity to increase their rehospitalization score.

(4) Establishing SNF Performance Scores – *No comment*

(5) Examples of Proposed FY 2019 SNF VBP Scoring Methodology – *No comments; we appreciate the examples to help understand how the scoring formula works.*

**A6. SNF Value Based Incentive Payments**

a. Background

CMS outlines the requirement of the SNV VBP in statute that the bottom 40 percent have a larger payment adjustment compared to the top 60 percent and that the incentive pool be based on 50 to 70 percent of the 2 percent withhold from SNF Part A payments. Payment adjustments must be published at least 60 days prior to the payment adjustment each year.

**AHCA Detailed Recommendations:**

- **AHCA strongly recommends that CMS make available 70 percent of the payment reduction for the incentive pool in the exchange function.**

  As CMS points out and the literature on VBP suggests, the larger the incentive, the greater the behavior change. Also, the greater the reductions in rehospitalizations, the greater the savings to the Medicare program from lower rehospitalizations. Therefore, we believe in keeping with the goals and purpose of the SNF VBP, CMS should make available the maximum amount of funds to create the largest incentive pool to have a larger impact on changing practice, which will reduce beneficiary readmissions and save the Medicare more funds. In fact, when the PAMA act was passed, the SNF VBP section savings were scored by OMB based on 70 percent of the withhold being returned to the SNFs.
b. Request for Comment on Exchange Function

CMS seeks input on four different exchange functions “to determine how best to reward high performance and encourage SNFs to improve the quality of care provided to Medicare beneficiaries.”

**AHCA Detailed Recommendations:**

- **AHCA recommends CMS consider a set of principles to evaluate the exchange function models to reward high performance and improve quality including:**
  - Top performing SNFs (e.g. very high rehospitalization score) should get an increase in their Medicare Rates
  - Exchange model should maximize the number of SNFs who do not see a cut in their rates,
    - Even if this results in more SNFs who are poor performing seeing a full 2 percent cut in their rates.
  - Model should create incentive for continued improvement, even if SNFs have above average rehospitalization scores.
    - Except, SNFs with very high rehospitalization scores should not be incentivized to keep improving, so the model does not incentivize keeping people out of the hospital who need to go to the hospital.
  - Differences in the rehospitalization score should be tied to meaningful differences in incentives (e.g. % NF Part A adjustment).
    - Even with its elaborate risk model, if there is an extremely narrow range of readmission rates where miniscule differences in readmission rates are rewarded with large differences in payment adjustments, then the SNF-VBP incentive will primarily be driven by variance in patient mix, and not variance in true quality performance.

In our evaluation, no one model is superior on all of these principles as there is often a tradeoff between maximizing one principle at the expense of another principle. AHCA conducted an evaluation of each model using national data for all SNFs. See AHCA’s website for complete evaluation of all four models.

- **AHCA strongly recommends that the exchange functions are set up so that top performing SNFs receive an increase in their payment rates above what they normally would receive.**

In order to create an incentive across a wide range of rehospitalization rates and continuous improvement (the stated goal by CMS in the SNF NPRM), the models best achieve this by allowing top performers to receive greater than 100 percent of their payment rate (e.g. an increase in payment or stated differently, SNFs receive more than 2 percent of their withhold). Under most
of the models, capping the top performers at receiving no increase, would result in a large portion having no further incentive to improve. While capping meets one of the AHCA proposed principles that top performers do not see a cut in their rates, it is at the expense of not meeting other principles and also not supporting CMS’s stated goal to create an incentive for a wide range of rehospitalization rates and continuous improvement. Assuming no cap, the logistic and cube function provide the best opportunity to create incentive for top performers they don’t operate as well for lower performing SNFs and don’t recognize meaningful differences and improvement as well. As such, we feel the logistic function is more flexible to adjustments in the size of the incentive pool and the maximum payments top performing SNFs receive. Therefore, we recommend the logistic function.

- **AHCA recommends the adoption of the logistic exchange function.**

  The logistic model we believe balances creating an incentive for rewarding top performers with no cut in payment and low performers to improve better than the other models. It also performs well with recognizing meaningful differences between SNF rehospitalization rates. It also has the most flexibility for changes in the program over time and adjustments to the size of the incentive pool. AHCA has conducted a full evaluation of all four models using national data calculated on all SNFs using the proposed scoring algorithm. The results of this full evaluation for each model are provided on AHCA’S website. The Table below summarizes the results of this evaluation when the incentive for top performers is not capped (see recommendation above) and is capped at no increase greater than the normal payment. We also calculate the models that had the greatest incentive for SNFs to achieve a 5 percent reduction in their rehospitalization rate from baseline to performance period. In reviewing these models against our proposed principles, some models perform better than others in one area but not as well in other areas. Overall, the logistic model performs the best when looking at meeting all the principles and also provides the most flexibility across the different options.

  The linear model has less flexibility and creates changes in payment adjustments for relatively small changes in rehospitalization rates that are not meaningful. The linear model more so than others has an extremely narrow range of readmission rates where very small differences in readmission rates are rewarded with large rate changes, which creates a SNF VBP incentive primarily driven by variance in patient mix and not variance in true quality performance. It also has the risk, depending on the size of the incentive pool, such that only a small proportion of top performers receive no payment adjustment (e.g. no cut).

- **AHCA does not recommend the cube root model under any circumstances.**

  The cube root model performs the worst against the proposed principles. It essentially creates very little incentive for performance improvement, top performers will still see a cut in their payment rates and there is little
recognition of any meaningful differences in rehospitalization rates as reflective on their score.

Figure 3. AHCA evaluation of four exchange functions

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<th>CMS Incentive Pool Size</th>
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<th>% SNFs with incentive for improvement³</th>
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³ Percentage of SNFs w/ ≥5% improvement who see ≥0.5% PPS rate increase vs if they had no improvement
A7. SNF VBP Reporting

a. Confidential Feedback Reports

CMS seeks comment on plans to use the QIES system CASPER files to provide feedback reports to SNFs on their rehospitalization performance starting in October 2016 and “any considerations CMS should take into account when designing and providing these feedback reports.”

Detailed AHCA Recommendations:

1. AHCA supports the use of the QIES system CASPER files to provide feedback reports to SNFs.

SNFs are used to receiving feedback reports via the QIES system on their Quality Measures posted on Nursing Home Compare (NHC) and Five Star information. All SNFs have access to this secure and confidential mechanism. Data reports should be in an excel format to allow manipulation and aggregation within an organization.

2. AHCA requests that provider organizations and others be provided access to this information by provider in order to share with providers as long as AHCA or any other organizations can assure that the data will remain protected AND only shared with representatives for that provider.

Many providers are part of larger organizations; the QIES system provides data by SNF. This requires larger organizations to manually download each SNF’s reports off of QIES and then to aggregate them into an organization wide report. This is time consuming and often requires manual data entry. Also, many providers have contracts with data analytic vendors who handle confidential patient level data (e.g. MDS) to provide feedback and benchmarking capabilities. These benchmarking tools help SNFs see how they are performing to peers, allows them to trend their performance over time and link the data with other quality metrics. This helps SNFs with their quality improvement efforts and also drives performance improvement as the literature shows, performance compared to peers is a powerful incentive to change. Both AHCA and Leading Age also provide similar benchmarking and trending reports. Also, providing this data would help facilitate the aggregation of data across SNFs within an organization into an organization report. We would request that CMS provide the national data file to organizations that can help facilitate the dissemination to individuals SNFs and to organizations that can provide assurances that only SNFs or their parent organization will see the individual SNF data. For example, in AHCA’s reporting tool, SNFs must provide a copy of their federal Medicare certification paperwork (i.e. form 850) to show their relationship to the SNF they are requesting to see data and the administrator from that organization assigns individual staff permission to see SNFs data. The website is a password protected system. AHCA would be open to other methods proposed by CMS that are not
burdensome to CMS to verify sharing of national data file only with the intended target audience.

3. *AHCA requests that CMS also use the QIES system to provide “real” time updates on a SNFs information as is currently done by CMS for SNFs QMs.*

CMS currently uses the QIES system to update each SNFs’ quality measures that are based on MDS data. Each week CMS uses information from MDS submitted to CMS to calculate the most recent rates on each QM, including the numerator and denominator data along with the patient’s name triggering each quality measure. CMS can develop a similar process using the SNF and Hospital Part A claims received each week to calculate and update a SNFs RM measure in the QIES system with names of beneficiaries that trigger the numerator (e.g. readmissions). This information will significantly help SNFs with their quality improvement efforts. This would also facilitate the requirement that SNFs “review and submit corrections to the information.” It will also create an incentive for more timely submission of claims to CMS.

b. Proposed Two-Phased SNF VBP data Review & Corrections Process

b1. Background

CMS proposes to provide two phases approach to comply with the Act’s requirement that SNFs have the opportunity to review and correct their data and that their data be publicly reported.

**Detailed AHCA Recommendations:**

1. *AHCA detailed comments: See later sections 2 and 3 below.*

b2. Phase One: review and correction of SNFs Quality Measure Information

CMS seeks comment on the proposal to provide SNFs with an annual confidential feedback report made available to SNFs via the QIES system CASPER files.

**Detailed AHCA Recommendations:**

1. *AHCA supports the use of QIES system CASPER files to provide feedback reports to SNFs. AHCA does NOT support allowing corrections on an annual basis and recommends allowing corrections on a quarterly basis with a final annual deadline.*

The data recommended to be provided in the quarterly reports should be sufficient to also allow checks of the accuracy of the SNF RM or SNF PPR calculations used to create the SNFs rehospitalization score. Thus, SNFs should be allowed to submit correction requests on a quarterly basis. Information in the report indicates rates higher than expected. Because of the delay in claims being submitted, data on readmissions may be missing. Missing
readmissions should be corrected on an annual basis on the final data to be used in the rehospitalization score used to adjust a SNFs Part A rate in the exchange function.

2. **AHCA does NOT support only providing annual reports but recommends, at a minimum, quarterly reports and/or weekly up-to-date preliminary reports through the QIES system as SNFs currently receive for the Nursing Home Compare publicly reported Quality Measures.**

See supporting discussion to recommendations #2 and #3 above in 7a. Confidential Feedback Reports.

3. **AHCA supports the proposed data to be included in the quarterly feedback reports, but also requests additional data be included via the QIES system as done with the MDS Quality Measures reported on NHC. The additional data should including the following:**

   (a) **Count of readmission that occur during and after the SNF Part A stay.** This will help SNFs with their quality improvement efforts to focus their efforts on transitions of care versus care during the SNF stay, as well as to improve their partnerships with providers following SNF discharge.

   (b) **Names of beneficiaries triggering the readmission.** This will help with SNFs quality improvement efforts, particularly for those readmitted after SNF discharge where information to the SNF is limited. This will allow them to work with post discharge providers to improve transitions of care and better coordination of care. This will also help SNFs with the review of the data and submission of correction requests. Additionally, it will facilitate CMS review of specific correction requests.

   (c) **Number of readmissions by PPR diagnosis.** As stated in the NRPM about SNF PPR, the readmissions related to diagnoses may related to “inadequate” care for that condition. Knowing the diagnoses leading to readmission will help SNFs better target their efforts to improve their clinical practices related to diagnoses driving their readmissions.

   (d) **Predicted and expected rates used to calculate the SSR for the prior rolling 12 month window.** AHCA recommends that the data be calculated each quarter for the SNF using a 12-month rolling window. Even though this data will not serve as the final data used in the rehospitalization score, it will allow SNFs to estimate who they will rank on their rehospitalization score;
which will be major incentive for SNFs to lower their readmission rates.

(e) National rates used to calculate the achievement and improvement score. This information is needed if the SNFs are to estimate their rehospitalization score using their predicted and actual

4. AHCA supports the use of a generic email address, the 30-day time frame and information required accompany any request to correct information ONLY if information in recommendation #4 above is included in the quarterly reports. Otherwise, it will not be possible for SNFs to comply with the proposal “submit documentation or other evidence” within 30 days of posting of the reports.

In order for SNFs to provide information about the accuracy of information and to facilitate CMS investigation of any correction request, they need to know the names of beneficiaries triggering the measure, when the readmission occurred (i.e. during or after the SNF stay) and the readmission diagnosis. SNF will also need to know the predicted and expected rates. AHCA appreciates that the volume of requests and the resources need to investigate requests to correct rates could be time consuming and difficult. Therefore, we recommend that CMS provide sufficient information to facilitate both the filing of any requests for correction but to also facilitate CMS investigation. We also appreciate that the delay in SNF and Hospital Part A claims being filed with CMS can make the appearance that a SNFs data is incorrect. Therefore, correction request for missing data should be restricted on once annually, but requests for corrections when patient’s admissions are listed incorrectly should be ongoing with each quarterly report.

5. AHCA requests that SNF and Hospital Part A claims be made available to organizations on a quarterly basis to help provide information to individual SNFs on both quality improvement and to facilitate correction requests with information to facilitate CMS investigation.

We recommend that CMS provide patient identifiable files to organizations that have a Business Associates Agreement (BAA) with the provider and allow the organizations to share that data with the providers including data with cells sizes less than 11. Most providers do not have the capacity to analyze claims data to help with quality improvement efforts and to understand their practice patterns. CMS also does not have the capacity to conduct in-depth data analyses and reports for each SNF. However, there are a large number of organizations currently working with SNFs that can provide this level of service. In addition, Leading Age and AHCA also have data analytic tools that can provide information
to individual SNF to protect identifiable data from being shared inappropriately.

Supplying this data may also help reduce correction requests filed with CMS. These organizations can conduct investigations on behalf of SNFs and explain many of the intricacies of claims and the measure specifications, which can reduce the number of correction requests.

**b3. Phase Two: Review and Correction of SNF Performance Scores**

CMS seeks comments on the information would most useful for SNFs to facilitate their review of their SNF performance scores and rankings. CMS proposes to restrict correction reports to the rehospitalization score only and not any data corrections from phase one reports. Also, all corrections must be submitted within 30 days.

**Detailed AHCA Recommendations:**

1. *AHCA recommends that SNFs have access to the information to calculate their hospitalization score and estimate their adjustment factor based on CMS’s final exchange function.*

   SNFs will want to replicate their rehospitalization score as close as possible. To do so, they will need their predicted rate, their expected rate, the national average, their rates for the baseline period and the performance period as well as the major “cut-points” used to determine points for achievement and improvement. Also, their ranking on the achievement and improvement scores as well as some guidance on their ranking on the rehospitalization score will be helpful. This will help SNFs feel more confident in their final payment adjustment but also will provide them with data to see how much more they need to improve to impact their rehospitalization score and thereby payment adjustment.

2. *AHCA opposes the ability of a SNF to request data correction in phase two, unless all the data in phase two is also included in the quarterly feedback reports in phase one and the last quarterly feedback report in phase one includes final data uses to calculate the rehospitalization score.*

   Data in the phase one quarterly feedback reports needs to be all the data used to calculate the rehospitalization score if SNFs are not able to file a correction request based on phase two feedback reports. The burden of submitting data correction requests on individual SNFs will be weighed against how much a change in data will impact their rehospitalization score. If there is little impact, they may not decide to submit a request.
Therefore, until a SNF is able to see its rehospitalization score, they may choose not to submit a data correction request.

c. SNF VBP Public Reporting

CMS proposes to post the SNF performance scores and number of SNFs receiving VBP payments (as well as the range and total amount of those payments) on Nursing Home Compare (NHC).

AHCA Detailed Recommendations:

1. **AHCA supports the posting of a SNFs rehospitalization performance score but NOT their rehospitalization rate or their achievement or improvement scores.**

   We do not support posting of achievement or improvement scores as this is neither required by statute nor helpful to consumers. We believe it may be confusing to the public when a SNF has a high achievement score but low improvement score, which would be expected since this means they maintained a very low rehospitalization rate. We do not support posting of the risk adjusted SNF RM or SNF PPR rates, since these measures differ from other rehospitalization measures that CMS is proposing in SNF QRP or using in Five Star and already posting on NHC. Having multiple rehospitalization rates from multiple measures will be very confusing to the public and others.

2. **We support posting of the aggregate payments and range of payments with number of SNFs receiving payment adjustments but do not support posting individual SNF payments.**

   Individual SNF payments will be a product of their rehospitalization score, their volume of SNF Part A admissions and their patient case mix RUG payments. The payment adjustment factor for each SNF could be provided but the actual payment adjustments should not as it will be confusing to the public given all the variables needed to understand. For example, a large SNF with a very small payment adjustment may have a larger aggregate payment change compared to a small SNF with a large payment adjustment. Publishing the payment adjustment factor and the volume of SNF Part A admission per year would be more helpful than the aggregate amount of the payment adjustment.

d. Ranking SNF Performance

As required in statute, CMS proposes to publicly report a SNF’s ranking on their rehospitalization score, ranked from low to high.

AHCA Detailed Recommendations:

1. **AHCA recommends that the direction and meaning of a ranking number needs to be clearly indicated in any public reporting of a SNFs rehospitalization ranking. Rank #1 should be reserved for the SNF with the best rehospitalization score, not the worst score.**
Regardless of CMS’s final decision to rank low to high or high to low, the public may misinterpret a SNFs ranking unless the ranking is clearly accompanied with clear and easy to understand information on the direction of the ranking. For example, a SNF ranked #1 when the ranking is low to high on the score could be misinterpreted as being the best in the country – when in fact, it would be the worst in the country. Generally, most rankings reserve rank #1 to be the best with statements ranked #1 out of X SNFs with lower rank number being better.

2. **AHCA supports posting the SNF ranking on the rehospitalization score on NHC website.**

AHCA should consolidate all public reporting on one website. Having data on multiple sites makes finding the information difficult and does not allow the interpretation of the data in the context of other quality data available on NHC.
Section 5: SNF Quality Reporting Program

NOTE: This section is organized by each heading in the SNF NPRM for the section A. Skilled Nursing Facility Quality Reporting Program (QRP). After each heading, we briefly summarize CMS’s proposal, which is followed by AHCA’s recommendations and supporting discussion.

Section B Quality Measures Previously Finalized for Use in the SNF QRP

B1. Background and statutory Authority – No comment

B2. General Considerations Used for Selection of Measures for the SNF QRP

CMS proposes to adopt one measure for medication reconciliation domain and three measures for the resource utilization domain. CMS outlines the process to “employ a transparent process” to seek public input including the use of Technical Expert Panel (TEP), Measures Under Consideration (MUC) process and general public comment requests.

ACHA supports the overall process by which CMS has used to seek public input but believes there are several factors impacting the quality of feedback, including: 1) short time frames provided for public input; 2) short time frames measure specifications were provided to the TEPs; and 3) the difficulty to allow public attendance as observers of the TEP process and material. Improving these would help create a transparent process with more meaningful public input. Many of the TEPs received measure specifications within a few days of meetings or conference calls, and most of the TEPs did not see the final proposed set of measures prior to CMS placing them on the MUC list. Also, CMS has not pursued NQF endorsement for any of the proposed measures. The NQF MAP process does not substitute for NQF endorsement. In addition, the MAP voted “encourage further development” for all four measures – and none as ready for final use in rule making.

AHCA Detailed Recommendations:

a. All measure TEPs should be open to public, and materials for the TEPs should be shared with the public.

b. CMS should provide information to TEPs with sufficient time to review the material (e.g. at least seven days).

c. TEPs should see the final draft proposed measure specifications and be able to comment on the final drafted proposed measures before CMS proceeds for endorsement by NQF or review of NQF MAP process for “fully developed measures.”

d. CMS should provide at least 30 days for public comment on posted measures rather than the one to two weeks afforded the public for several of the proposed measures.

e. Measures reviewed by the NQF MAP process that receive “encourage further development” should not be finalized through rule making.
However, CMS may consider using the proposed rulemaking as an additional process to review public comment and further develop/refine the measures when the NQF MAP’s final recommendation is to “encourage further development.”

B3. Policy for retaining SNF QRP Measures adopted for future Payment determinations – No comments

B4. Process for Adoption of changes to SNF QRP Measures – No comments

B5. Quality Measures Previously Finalized for Use in the SNF QRP

CMS provides Table 12 with the measures finalized in SNF NPRM 2016 rule for annual payment determination in FY 2018.

AHCA Detailed Recommendations:

1. AHCA recommends that CMS submit the measures finalized in the 2016 rule that are listed in Table 12 for NQF endorsement.

While the measures were finalized in 2016 rule for data collection to start in October 1, 2016, the measures don’t go into full effect for public reporting or payment determination until FY 2018. None of the measures finalized last year were submitted for NQF endorsement. The IMPACT Act requires that the Secretary seek NQF endorsement unless certain exceptions are met:

“(2) CONSENSUS-BASED ENTITY.—

(A) IN GENERAL.—Subject to subparagraph (B), each measure specified by the Secretary under this section shall be endorsed by the entity with a contract under section 1890(a). “

(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.”

The exception applies when due consideration is given to measures that have been endorsed. The act did not say if no endorsed measure is available, the Secretary can propose or consider any measure. Rather only other measures that “have been endorsed or adopted by a consensus organization.” A reasonable interpretation of this statute would assume that the Secretary needs to seek and receive NQF endorsement for any proposed measure when no endorsed measure exists. AHCA appreciates that seeking such endorsement given the timelines outlined in the IMPACT Act may make complying with the timelines difficult, but we believe that is an incorrect interpretation of the IMPACT Act language. Nonetheless, now that the measures have been specified within the IMPACT timelines, there is time available to CMS to seek NQF endorsement prior to FY 2018 implementation. Therefore, AHCA recommends that CMS submit the measures finalized in the 2016 rule that are listed in Table 12 for NQF endorsement.
B6. SNF QRP Quality, Resource Use and Other Measures for FY 2018 Payment Determinations and Subsequent Years

CMS outlines three resource use measures to comply with the Impact Act for FY 2018 payment determination and seeks comment on the use of sociodemographic status (SDS) in the risk adjustment of these three measures.

AHCA Detailed recommendations:

1. SDS characteristics generally should not be included in within stay measures but may be considered for measures evaluating care after SNF discharge. Any analysis of SDS characteristics needs to take into consideration the provider effect on quality of care in addition to the SDS effect.

2. The three resource proposed resource measures should NOT be finalized until they receive NQF MAP recommendation as “support” or “conditional support” for a fully developed measure. Measures receiving a recommendation of “continued further development” should not be finalized when specified in a proposed rule.

3. CMS should submit the three resource measures for NQF endorsement prior to proposing the adoption in rule making or at least commit to a timeline for NQF endorsement in the rule for measures that are proposed that do not have NQF endorsement.

The three resource measures proposed by CMS all were reviewed by NQF MAP process and received a recommendation of “encourage further development.” None received a vote of “support” or “conditional support” for fully-developed measures. As such, AHCA does not believe these three proposed resource measures should be finalized. Prior to being finalized, they should be submitted as fully-developed measures and receive a vote of “support” or “support with conditions” before being finalized.

The use of SDS is a broad term with varying arguments on their use in risk adjustment for measures used in accountability programs (e.g. public reporting or payment). The use of SDS measures in risk adjustment to explain as much of the variation in care should generally be done, but when used in risk adjustment for accountability measures, is much more controversial and depends on the measure. Within stay measures for the SNF setting, AHCA generally supports the exclusion of SDS measures (e.g. ethnicity), but for measures about care and outcomes after SNF discharge back to the community, they need to be taken into consideration on a measure by measure basis. Adjusting for SDS characteristics for within stay measures may have the inadvertent effect of adjusting for poor quality providers.

As outlined in AHCA’s submission to NQF for rehospitalization measure (i.e., NQF # 2375) in the trial period review of SDS adjustment, we have found that SDS characteristics do not add much if anything at all to risk adjustment models when you also adjust for the facility effect. In other words, SNFs with higher prevalence of patients with certain SDS characteristics tend to provider lower quality of care to all residents regardless of SDS, but individuals with these SDS
characteristics tend to concentrate in certain SNFs. This gives the appearance that SDS characteristics are associated with the outcome of interest when in fact they are not. However, when looking at measures that evaluate outcomes after discharge back to the community, SDS characteristics are more likely to play a role in explaining differences not explained by other clinical characteristics and not related to the quality of care of the provider.

a. Proposal to address the IMPACT Act domain of resource use and other measures: Total Estimate MSBP – PAC SNF QRP

CMS is proposing an MSPB-PAC SNF QRP measure for inclusion in the SNF QRP for FY 2018 payment determination and subsequent years. New measure development support documentation not previously available was included in the NPRM via web links. The only invitation for public comment was: 1) on the overall proposal to adopt the MSPB-PAC SNF measure as presented for the SNF QRP and 2) how socioeconomic and demographic factors should be used in risk adjustment for the MSPB-PAC SNF measure.

AHCA Detailed Recommendations:

- AHCA opposes the adoption of the MSPB-PAC SNF measure for the SNF QRP at this time and recommends further development.
  - It does not align with IMPACT Act.
  - It has not received NQF endorsement.
  - NQF MAP recommended continued further development, and not all MAP concerns were addressed in the proposed rule
  - The proposed model has weak predictive power.

- AHCA supports the inclusion of socioeconomic and demographic factors in the MSPB-PAC SNF measure before adoption.

AHCA opposes the adoption of the MSPB-PAC SNF measure for the SNF QRP at this time, and recommends further development.

Insufficient Alignment with IMPACT Act

AHCA does not believe that the proposed MSPB-PAC SNF measure complies with the intent of the IMPACT Act because 1) it is not a cross-setting measure and 2) it is not clearly tied to meaningful clinical quality measures.

1. The IMPACT Act established a detailed process through which critically important data and information will be collected, analyzed and synthesized across PAC settings. The thoughtful analysis of these data and appropriate stakeholder engagement in developing meaningful quality and resource use measures could provide the foundation for significant changes to post-acute quality and payment policies aligned with the triple aims of the National Quality Strategy of better care, smarter spending, and healthier people. AHCA agrees with the recent MedPAC comments to CMS regarding this proposed rule, which states, “...the goal of cross-cutting measures is to gauge and compare care provided across
PAC settings...so that Medicare can evaluate the value of its purchases and beneficiaries can make informed choices about where to seek care.”

The IMPACT Act specifies that the MSPB-PAC measure include total estimated Medicare spending per beneficiary across PAC settings. Instead, the proposed measure is a setting-specific total estimated Medicare Spending per Episode (MSPE) measure. Such a construction will not permit meaningful comparisons of spending for beneficiaries with similar characteristics across PAC settings. In addition, it will not permit meaningful comparisons of spending for beneficiaries with similar characteristics in the same setting, particularly for beneficiaries with complex needs. The proposed measure would instead carve up interrupted SNF stays into multiple MSPB-PAC “episodes” within the same provider.

Evaluating the resources needed to care for beneficiaries with such complex needs is exactly what the IMPACT Act MSPB-PAC measure was intended for. Designing a measure that does not permit a meaningful evaluation of care management within and between PAC providers for this important segment of the population by carving up a beneficiary’s care pathway experience into multiple overlapping “episodes” is counterproductive. It will serve to shield, rather than expose the care needs of the most vulnerable beneficiaries. AHCA agrees with the recent MedPAC recommendation that instead of using four separate setting-specific MSPB-PAC measures, that CMS adopt a “uniformly defined resource use measure for all four PAC settings.” AHCA also concurs with MedPAC that until setting-specific differences that CMS has identified can be mitigated, setting-specific performance could be evaluated using the single cross-setting measure.

2. AHCA believes that the IMPACT Act intended to apply a resource use measure for quality and public reporting purposes that is clearly tied to clinically meaningful outcomes measures. Provider performance should reflect ‘Value,’ demonstrated by effective care that is efficiently provided, and should not disproportionately incentivize cost-containment approaches as a higher priority than quality care. AHCA requests that CMS clearly describe the framework and process that the MSPB-PAC measure is to be linked to quality outcomes measures before this measure is finalized.

Additionally, a repeated theme in the MSPB-PAC Public Comment Summary Report and Supplementary Materials are statements such as the following: “In the future, when standardized assessment data are available, CMS may revisit this and carefully evaluate whether a single cross-setting MSPB-PAC measure is possible.” In addition, the report notes, “The statutorily mandated deadlines for the IMPACT Act have compressed the timeline for the measure development process and limited the amount of time available for public comment and review.” Both of these statements, along with the weak predictive power reported for the MSPB-PAC SNF measure (discussed below), are strong indicators that additional factors need to be evaluated and added to the measure design before it satisfies the IMPACT Act requirements. Implementing an unsatisfactory measure to meet a statutory deadline could have negative unintended consequences on
beneficiary care. AHCA requests that these limitations be addressed before the MSPB-PAC measure is finalized.

In addition, AHCA strongly disagrees with the CMS approach to rely exclusively on administrative claims data for the MSPB-PAC SNF measure. Per the IMPACT Act, “the Secretary shall specify resource use and other measures on which PAC providers are required under the applicable reporting provisions to submit any necessary data specified by the Secretary, which may include standardized assessment data in addition to claims data.” AHCA recommends that the weak predictive power of the claims-only approach to this measure requires CMS to revise its approach and include meaningful variables obtained through assessment data prior to finalizing this measure, which is clearly supported as permissible in the legislative text.

Currently, the measure only captures diagnosis from claims. However, one of the strongest predictors of resource utilization in the elderly are functional metrics (e.g. ADL) and cognitive function, which are available for all PAC providers from their assessment tools. The risk adjustment models need to include clinical characteristics such as functional status and cognitive function. For example, not all people with chronic obstructive pulmonary disease (COPD) are at the same risk for rehospitalization and healthcare utilization. An individuals with COPD who can only walk a few feet and has cognitive impairment limiting his/her ability to use their medications reliably will have much greater needs than an individual with COPD who can walk and drive a car without any cognitive impairment.

However, the current approach only captures if a person has COPD or not, even though information on functional status and cognitive function exists.

**Lacks NQF Endorsement**

AHCA notes that the IMPACT Act provisions indicate Congressional preference to measures endorsed by a “consensus-based entity,” and that the proposed MSPB-PAC measure lacks such endorsement. While the statute provides an exception that would permit CMS to adopt a measure that has not received such endorsement, this only applies when other NQF-endorsed measures exist. We believe that any measure adopted under this exception should still be subject to “due consideration.” We do not believe that this threshold has been met. In addition, the NQF MAP was also unable to consider recommending the MSPB-PAC SNF measure for rule making because as of the February 2016 NQF MAP meeting, the measure was not fully-specified and was considered to be “under development.”

**NQF MAP recommended continued further development, and not all MAP concerns were addressed in the proposed rule**

In the February 2016 NQF Process and Approach for MAP Pre-Rulemaking Deliberations, 2015-2016: Final Report, NQF MAP members noted the importance of balancing cost measures with quality and access. Although the MAP encouraged continued development of the MSPB-PAC SNF measure, it did note concerns about the potential for unintended consequences.
In particular, the MAP raised concerns about issues of premature discharges from SNF to home and ability to make comparisons across providers. The MAP noted this could put a tremendous burden on family caregivers who may have to care for a patient they are not fully able to support. AHCA shares these concerns, as this highlights our concern that it is essential that resource use measures be cross-setting and linked to meaningful clinical quality measures prior to implementation.

MAP members noted the need to consider risk adjustment for severity and socioeconomic status and urged CMS to incorporate functional status assessments into risk adjustment models to promote improvements. AHCA shares these concerns and notes that the proposed risk adjustment methodology does not address socioeconomic or functional status. As a result, the predictive power of the MSPB-PAC SNF model is weak.

The MAP noted the measure was never fully-specified before deliberations and also requested consideration in the finalization of specifications to ensure costs are not double-counted between care settings. It also recommended submission to NQF for endorsement prior to implementation. CMS is instead proposing to finalize the unendorsed measure with minor revisions that to not address the stated NQF concerns. AHCA concurs with the MAP that the MSPB-PAC SNF measure should receive NQF endorsement prior to finalization.

**Weak Predictive Power of Model**

AHCA believes that the proposed measure is extremely complex and does not offer a transparent mechanism for PAC providers to evaluate in real-time many of the risk-factors and other variables used in the measure construction that may impact their decisions. As the number of unknowns increases and if the model is known to poorly identify beneficiary resource needs, a providers risk tolerance decreases, which may impact beneficiary access to care and quality of care.

Per Table 8 of the *Public Comment Summary Report: Supplementary Materials*, the Adjusted-$R^2$ value of 0.097 for the SNF MSPB—PAC measure is quite weak, indicating that the available claim level information proposed for this measure is insufficient to reflect a SNF providers performance on resource-use, which is the intended purpose of this measure. In contrast, the LTCH Standard model has a much stronger Adjusted-$R^2$ value of 0.490.

Resource use measures that perform poorly at adequately identifying the expected resource use of beneficiaries with complex care needs can create access to care issues for beneficiaries with such needs. Additionally, such measures place providers that care for a disproportionate percentage of beneficiaries with such care needs at a disadvantage in the measure scoring methodology. Much research supports that HCCs are a poor predictor of SNF utilization needs, and that better and more meaningful indicators of patient health and function are available from more accessible SNF patient assessment data. AHCA believes that CMS should not finalized the MSPB-PAC measure until better clinical and demographic data is identified that a provider has readily available and will adequately reflect the cost of care needs for at-risk patient populations.
At a minimum, CMS needs to incorporate functional and conative status into the risk adjustment model. This may help improve the predictive power since functional status is a major drive of health care utilization.

**AHCA supports the inclusion of socioeconomic and demographic factors in the MSPB-PAC measure before adoption.**

AHCA believes that the proposed MSPB-PAC measure should adjust for socioeconomic and demographic factors before it is finalized, or at least explore how much they impact the risk adjustment model. Failure to account for very real differences in underlying patient health status and support systems that would permit more timely discharge to community results in the demonstrated poor predictive power of the MSPB-PAC resource use measure as applied to SNF patients. By ignoring these factors, it may place providers that disproportionately provide care for such populations at a disadvantage in a resource use performance measure. We believe that, in the context of a resource-use measure which in this proposed rule is not currently tied to any outcomes measure, the risks to access to care quality of care are too important to ignore.

To best achieve this in the short-term as CMS awaits further analysis from NQF and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), AHCA agrees with the interim approach suggested by MedPAC in its recent comments pertaining to this proposed rule. Specifically, MedPAC suggested making cost comparisons “…across ‘peer’ providers that have similar shares of, for example low-income beneficiaries.” As MedPAC argued, the comparisons would be more “…‘fair’ because providers are compared with other providers with similar shares of low-income beneficiaries.” Based on our internal analyses, AHCA recommends including at a minimum, currently available dual-eligibility status and gender administrative claim factors, and consider testing other socioeconomic factors that are currently available on MDS assessment data for inclusion before the MSPB-PAC measure is finalized.

**AHCA Comments to Specific Proposed Changes from the Draft Measure Specifications (Appendix 1 of April 2016 Measure Specifications: MSPB-PAC Resource Use Measures)**

As discussed in the general comments above, AHCA strongly believes that the proposed setting-specific MSPB-PAC SNF measure is inconsistent with the IMPACT Act and should not be finalized. However, if CMS continues to pursue the path of adopting this measure, AHCA offers the following comments in the spirit of making the measure as consistent across settings as possible – so that a true site-neutral MSPB-PAC measure as intended by the IMPACT Act can potentially evolve from this foundation.

- AHCA supports the addition of a hospice services utilization indicator in the proposed risk adjustment methodology.

- AHCA supports the addition of recent prior inpatient stay length and prior ICU stay length brackets in the proposed risk adjustment methodology.
• AHCA supports the proposed exclusion of episodes where a claim constituting treatment is not reimbursed under the SNF PPS.

• AHCA supports the division of the “Prior PAC” clinical case mix risk adjustment category into two categories for prior institutional versus prior home health care.

• AHCA agrees, based on the rationale presented, that the proposed use of clinical case mix categories as dummy variables in risk adjustment could be used rather than a fully integrated model. The data presented suggests that it doesn’t matter, and dummy variables are much ‘cleaner.’

• AHCA agrees, based on the rationale presented, the proposed order of priority to determine clinical case mix categories between two competing IP claims with the same end date.

• AHCA agrees that the list of clinically unrelated services provided in the MSPB-PAC SNF Clinically Unrelated Services Excel file appears to be fairly comprehensive.

• AHCA supports the proposed Winsorization of low predicted values and high spending outliers to improve measure calculations.

AHCA appreciates the detailed Public Comment Summary Report and Supplementary Materials, which helped inform our ability to comment on the episode construction details below.

1. Episode Construction

• AHCA agrees with the proposal that the MSPB-PAC episode window is comprised of a treatment period and an associated services period.

Treatment Period

• AHCA agrees with the proposal concept that the MSPB-PAC treatment period begins at the trigger (day of SNF admission) and ends at the day of discharge from that SNF. However, AHCA seeks that the definition be clarified so that the trigger is defined as the first day of SNF FFS coverage and the discharge is defined as the last day of SNF coverage. This is because some beneficiaries may reside in a SNF bed prior to qualifying for SNF FFS coverage and some may remain in a SNF bed (e.g. for long term nursing care) after SNF FFS coverage ends.

Readmissions

• AHCA agrees with the proposal that two sequential SNF PPS stays to the same SNF within seven or fewer days do not trigger a new MSPB-PAC episode, and readmissions after this period are treated as a new episode.
Associated Services Period

- AHCA agrees with the proposal that the MSPB-PAC associated services period begins at the episode trigger and ends 30 days after the end of the treatment period.

Opening (Triggering) Episodes

- AHCA agrees with the proposal that the MSPB-PAC episode begins at the trigger, under the condition that the definition of the trigger is defined as the first day of SNF FFS coverage as described above.

2. Measure Calculation

AHCA appreciates the detailed Public Comment Summary Report and Supplementary Materials and April 2016 Measure Specifications document that helped inform our ability to comment on the measure calculation details below.

(a) Exclusion Criteria

Service Level Exclusions

- AHCA agrees with the proposed MSPB-PAC service level exclusions.

Episode Level Exclusions

- AHCA agrees with the proposed MSPB-PAC episode level exclusions.

(b) Standardization and Risk Adjustment

Payment Standardization Methodology

- AHCA agrees with the proposed payment standardization approach to remove MSPB-PAC geographic payment differences.

Risk Adjustment

- AHCA appreciates the additional analyses that resulted in the proposal to include several new proposed covariates in the risk-adjustment model, including 1) adding both “Prior PAC-Institutional” and “Prior-PAC-HHA” instead of just one “Prior PAC” variable and 2) adding a hospice indicator variable. AHCA supports the addition of these additional variables.

- AHCA strongly opposes the overall MSPB-PAC SNF risk adjustment methodology.

  - Per Table 8 of the Public Comment Summary report, Supplementary Materials, the Adjusted-R² value of 0.097 for the SNF MSPB—PAC measure is quite weak, indicating that the available claim level information proposed for this measure is insufficient to reflect a SNF providers performance on
resource-use, as is the intended purpose of this measure. Much research supports, that HCCs are a poor predictor of SNF utilization needs and that better and more meaningful indicators of patient health and function are available from SNF patient assessment data.

- The proposed MSPB-PAC measure risk adjustment methodology is not NQF endorsed.
- The proposed MSPB-PAC measure does not adjust for socioeconomic and demographic factors. AHCA proposes testing currently available dual-eligibility status and gender administrative claim factors and similar factors that are currently available on MDS assessment data.
- The proposed MSPB-PAC measure does not adjust for function, which much research demonstrates is a better predictor of PAC need, resource use, and outcomes.
- Additional variables that AHCA recommends should be tested not otherwise mentioned above include: prior emergency room use (to capture labile health status and to capture observation stays), number of prior hospital admissions, cognitive status (e.g. dementia diagnosis in claims history), and mental health status (e.g. depression).

(c) Measure Numerator and Denominator
- AHCA agrees with the proposed MSPB-PAC measure Numerator and Denominator definitions.

3. Data Source
- As described in the risk adjustment methodology comments above, AHCA opposes the exclusive use of administrative claims based information in the construction of the MSPB-PAC measure.

4. Cohort
- AHCA agrees with the proposed cohort that “includes Medicare FFS beneficiaries with a SNF treatment period ending during the data collection period.”

5. Reporting
- AHCA strongly opposes public reporting of the MSPB-PAC measure unless it has first received NQF endorsement.
- AHCA recommends a reasonable period be permitted for providers to review and correct data errors identified in feedback reports prior to public reporting.
- AHCA does not support the proposed minimum of 20 episodes for reporting and inclusion in the SNF QRP. With the relatively weak predictive power of
the MSPB-PAC SNF measure, we believe that low volume SNFs would be disadvantaged due to the large unknown variability in the proposed risk adjustment model. As such, differences between SNFs on the measure will represent differences in patient populations rather than differences in the delivery of care and costs of care.

b. **Proposal to address the IMPACT Act domain of resource use and other measures: Discharge to Community-Post Acute Care Skilled Nursing Facility Quality Reporting Program**

Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) reports “SNF’s risk-standardized rate of Medicare FFS residents who are discharged to the community following a SNF stay, who do not have an unplanned readmission to an acute care hospital or LTCH in the 31 days following discharge to community, and who remain alive during the 31 days following discharge to community.” The measure is based on Medicare FFS administrative claims (i.e. Medicare eligibility files and inpatient claims). “Community” is defined as home/self-care with or without home health services. More specifically, this is noted as 01, 06, 81, or 86 on the Patient Discharge Status Codes on the Medicare FFS claims.

We appreciate CMS’s efforts to develop three similarly constructed but unique risk adjusted discharge to community measures for IRF, SNF, and LTCH setting, respectively, as these settings have different patient profiles. Furthermore, it is important that these measures are conceptually uniform across the settings with regards to definition of discharge to community outcome, risk adjustment approach, and the measure algorithm/calculation as consistent with the intent and purpose of the IMPACT Act. We also appreciate/support the fact that although the measure was developed with ICD-9 procedure and diagnosis codes, the measure will be revised using the ICD-9 to ICD-10 cross-walk.

**AHCA detailed Recommendations:**

1. *The name of the measure should reflect the limited population to which it applied- fee-for-service (FFS) Medicare beneficiaries.*

   This is important because in many states, 40 percent or more of Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans. For SNFs, over half of SNF admission and discharges are not enrolled in FFS Medicare. As such, given the payer mix among SNF admissions and discharges, the measure may not reflect a SNF’s true discharge to community rate. Therefore, changing the name to *Discharge to Community-Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program: Fee for Service Residents* is more reflective of the population for which this measure is intended.

2. *The measure does not exclude individuals admitted to a SNF for Part A services, but who have an expressed goal to remain in the SNF for long term care and never be discharged back to community.*
This concern was raised by the MAP and provided in their comments, which were not addressed in this proposed rule. In fact, when we compare discharge to community rates as a relationship to the turnover of patients in Part A beds, those SNFs with low turnover (a marker consistent with being primarily long term care facilities) have low discharge rates, while SNFs with high turnover of beds have higher discharge to community rates.

3. *Failure to exclude individuals admitted to a SNF who were residents of a SNF prior to the hospital stay is inappropriate since they are residents of long term care facility and would not be expected to be discharged to the community following Part A services.*

There are approximately 1.1 million long term residents of which nearly one-sixth are admitted to the hospital and sent back to the SNF each year.

4. *The numerator definition of alive 30 days after discharge to the community will discourage discharging individuals to their home who are dying.*

We appreciate that those who die in the next 30 days after discharge who are also enrolled in hospice will be excluded but believe these should not be excluded. Rather, we believe they should be counted as successful discharge to the community as opposed to being excluded. Otherwise, the measure creates an incentive to not discharge individuals who are dying but to keep them in the SNF, or worse, send them to the hospital and reverses years of effort by CMS, policy makers and providers to improve the dying process for the frail elderly.

5. *The numerator should not count individuals who during their 30 day discharge window are admitted to a SNF.*

Individuals discharged home but who then are admitted back to a SNF or NF because they could not reside at home should not be counted as successful discharge. This can easily be assessed by using the MDS to identify individuals admitted to any SNF. This concept should be applied to all the PAC Discharge to community measures since the MDS linked with claims is available for all patients discharge from PAC providers.

6. *The risk adjustment model needs to also include functional status (i.e. ADL, mobility, self-care, and cognitive function), as they are some of the strongest predictors of successful discharge to community.*

In AHCA’s Discharge to Community measure that is risk adjusted and uses MDS data, we found that many of the clinical variables retained in the model and often the strongest risk adjustment variables included functional status and cognitive status. This is consistent with the literature that shows higher functional status as a strong predictor of one’s ability to live independently in the community and lower functional status as a strong predictor of requiring long term nursing home placement.
7. **Case mix groups is only listed as a risk-adjusted variable for LCTH setting but should also apply to IRFs and SNFs as well.**

c. **Proposal to address the IMPACT Act domain of resource use and other measures: Potentially Preventable 30-day post-discharge readmission measure for skilled nursing facility Quality Reporting Program**

CMS proposes a potentially preventable rehospitalization (PPR) measure for individuals discharged from the SNF. This is a risk-adjusted measure based on Part A claims and thereby measures only individuals in the Medicare FFS program and does not count readmissions classified as observation status, since observation stays are covered under Part B. The measure excludes elective readmissions. It also only counts readmissions with a primary diagnosis on the readmission claim that is considered potentially preventable. CMS defines potentially preventable as “a readmission for which the probability of occurrence could be minimized with adequately planned, explained and implemented post-discharge instructions, including the establishment of appropriate follow-up ambulatory care.” The risk adjustment calculates a “predicted actual” readmission rate compared to the “expected readmission rate” and multiplies the ratio by the national average readmission rate. The measure follows the same logic as the SNF PPR to be used in the SNF VBP program and also follows the same logic for similar measures applied to IRF and LTCH patients.

**AHCA Detailed Recommendations:**

1. **CMS should not finalize the measure, as the full measure specifications are not provided to allow adequate public comment.**

   The link provided for the measure specifications are in a technical report was not available to the TEP or NQF MAP to review prior to posting of SNF NPRM. The risk adjustment model is new. While we appreciate the time pressures CMS is under to specify the measure by October 1, 2016, we do not believe the proposed measure that will impact Medicare beneficiaries access to and deliver of care as well as SNF payment should be rushed to meet an deadline and when congress has indicated the measure should be used “as soon as practicable.”

2. **CMS should not finalize this measure, as the NQF MAP only voted to recommend this measure as “encourage further development.” NQF MAP did not vote to “support” or “support with conditions.” CMS should submit this measure for NQF endorsement as specified in the PAMA Act.**

   The measure was not finalized and was still under development when presented for public comment and to the NQF MAP (“at the time, the risk adjustment model was still under development.”) Given the NQF MAP recommendation to continue further development,” this measure should not be finalized but resubmitted to the NQF MAP as a fully developed measure once it has received NQF endorsement. The IMPACT Act requires measures to be NQF-endorsed unless due consideration was given to other NQF endorsed
measures. Since there are no other SNF post discharge PPR measures available, CMS should only proposed NQF endorsed measures.

3. **CMS should use an “actual readmission rate” to calculate the standardized Risk Ratio (SSR) rather than predicted or show empirically how a “predicted actual” results in significant different rankings of SNFs to justify this more complicated and less easy to understand methodology.**

CMS states that the numerator of the measure “does not have a simple form for the numerator – that is, the risk adjustment method does not make the observed number of readmissions the numerator.” Rather, the numerator is as stated in the technical manual “mathematically related to the number of residents in the target population who have the event of a potentially preventable, unplanned readmission (PPR definitions and planned readmissions are described below) during the readmission window (i.e. 30 days post prior hospital discharge).” AHCA understand the statistical rationale for using risk-adjusted estimate versus actual readmission rate in the SSR, but does not believe that it provides superior or more accurate information than just the actual admission rate. In fact, it will provide more confusing information. It is not easy for providers to understand or replicate. It will not match their own actual rates leading to more appeals for inaccurate data, questioning the accuracy of the data and less likely to use the data in their quality improvement efforts. CMS should show the use of predicted actual results in different rankings (the rates will differ between the two methods). But, the rankings – which matter in this program and in public reporting programs – is unlikely to differ. If there is not a great difference between methods, we would recommend using the simpler of the two methods. This logic of picking a simpler method is provided by CMS in several arguments supporting a proposed approach or measure elsewhere in the SNF NPRM. We would argue the same logic should apply to the decision to choose a “predicted actual” or “actual” readmission rate in the SSR.

4. **The risk adjustment variables should include functional and cognitive status.**

Functional status and cognitive status are one of the strongest predictors of future health care utilization. Currently, the risk adjustment is limited to demographic, diagnosis, and procedure codes from claims. No functional or symptoms are included. The MDS contains a wealth of information on functional and cognitive status. With the purpose of the IMPACT Act to create standardized assessment instruments and PAC measures, we believe the IMPACT Act measures risk adjustment needs to include such variables. All PAC instruments contain such information, albeit using slightly different assessments until later this year when CMS mandates the use of section GG for functional assessment and later for cognitive assessment. The variations in the ADL assessment tools used in the different PAC settings should not restrict their use in risk adjustment. It is better to include them in risk adjustment even though they differ than to leave out the information all together.
5. **AHCA generally supports a minimum denominator size of 25 as specified in the technical manual, but prefers 30, which will yield less variability from the randomness of patients admitted during the year despite risk adjustment. Also see comments on minimum denominator size for use in the SNF VBP rehospitalization score calculations.**

CMS typically uses a minimum denominator size of 20 for short stay or 30 for long stay quality measures reported on nursing home compare. Analysis of quality measures (e.g. bootstrap analyses) will show that the variability in measure for a single provider starts to increase when the denominator size drops below 50 and significantly increases after 30 increasing to unacceptable levels at 20. Thus, smaller SNFs with less than 30 Medicare FFS admissions a year can result in large year to year variation in rates and large variation in the randomness of patients admitted to their SNF. This variability increases significantly between 30 and 20. While 25 is better than 20, we believe 30 should be used as the minimum denominator size for the SNF PPR. Given that the SNF PPR will be used in the SNF VBP to adjust payment rates up to 2 percent for an entire year, we would recommend CMS at least show the data on how much variation occurs between SNF PPR rates when a minimum denominator size of 25 versus 30 are used. Smaller size SNFs should have the window for cases counted expanded from 12 months to 24 months when their denominator drops below 25.

6. **AHCA recommends CMS use language when describing the measure and justification consistent with the definition that these readmissions are potentially preventable, not preventable.**

The literature demonstrates that even with ideal care consistent with all standards of practice and the last guidelines, many of these admissions still occur. We agree that they are potentially preventable and support that terminology. However, CMS uses terms to justify the diagnoses selected as “should be avoidable” rather than “may be avoidable.” Terminology justifying the diagnoses that count as PPR repeatedly refer to “inadequate management” (i.e. “inadequate management of chronic conditions,” inadequate manage of infections,” and “inadequate management of other unplanned events.”) Also, in estimating the cost savings, CMS assumes or cites literature that assumes 100 percent of the readmissions were preventable. This is inconsistent with the definition and literature on potentially preventable readmissions and provides misleading information on the potentially impact this measure may have on practices. The original measure – developed by AHRQ and serving as the basis for this measure per the background – was to assess the availability and access to services in a community and measured readmission rates in a community, not by individual providers. However, this measure has been extended to individual hospitals and then other providers. Again, this is not an unreasonable idea, but the language and measure construction needs to be modified to account for the use measuring individual providers rather than the access to services in a community at large. The language used by CMS in the NPRM also implies that the goal of this measure should be zero. A SNF
PPR rate of zero in many facilities, particularly in facilities with larger volume of short stay residents, can only be achieved by denying hospital services to needed individuals. We do not believe that is CMS’s intent with the use of this measure. The context and description of this measure will be important in how the providers, consumers and policy makers interpret and respond to the results of this measure.

B7. Skilled Nursing Facility Quality Measure Proposed for the FY 2020 Payment Determination and Subsequent Years

AHCA recognizes and supports the importance of the four measures proposed for FY 2020 payment determination. The NQF MAP voted “encourage further development” for all four measures. None received either a vote of “support” or “support with condition.” None of the measures, when presented to NQF MAP, were in the final condition, and as per NPRM, the risk adjustment models and other details were not available to the NQF MAP; CMS has continued to revise these. In addition, many of the comments made by NQF MAP were not addressed in the SNF NPRM as required. Finally, none of the four measures have been submitted to NQF for endorsement as outlined in the IMPACT Act.

AHCA Detailed Recommendations:

- **CMS should not finalize any of the four measures.**
  
  None of the four measures received a vote of “support” or “support with conditions” by the NQF MAP. Rather the NQF MAP voted “encourage further development” for all four measures.

- **CMS should seek NQF endorsement as outlined by IMPACT act.**
  
  The IMPACT Act requires that the secretary shall use an NQF endorse measure or, when proposing a non-NQF endorsed measure, the secretary must provide “due consideration…to measures that have been endorsed or adopted by” NQF. This language does not say CMS can propose a non-NQF endorsed measure if there is no NQF endorsed measure. None of the proposed measures have NQF endorsement and no due consideration was provided for any other QNF endorsed measures, because none exist.

  “‘(2) CONSENSUS-BASED ENTITY.—

  ‘‘(A) IN GENERAL.—Subject to subparagraph (B), each measure specified by the Secretary under this section shall be endorsed by the entity with a contract under section 1890(a).

  ‘‘(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a
consensus organization identified by the Secretary.

- CMS should not finalize the measures until it address the MAP feedback as requires.

The statutory language creating the MAP process, requires that the Secretary “shall take into consideration the input from” the NQF “in selecting quality and efficiency measures.”

"(4) CONSIDERATION OF MULTI-STAKEHOLDER INPUT.-The Secretary shall take into consideration the input from multistakeholder groups described in paragraph (1) in selecting quality and efficiency measures described in section 1890(b)(7)(B) that have been endorsed by the entity with a contract under section 1890 and measures that have not been endorsed by such entity.

Not all of the feedback from the NQF MAP was addressed in the SNF NPRM, thus it is not possible to determine how the secretary took “into consideration the input from” the NQF MAP.

7a. Quality Measure Addressing the IMPACT Act Domain of Medication Reconciliation: Drug Regimen Review Conducted with Follow-Up for Identified Issues – Post Acute Care (PAC) Skilled Nursing Facility Quality Reporting Program

Background: CMS proposes to adopt the quality measure Drug Regimen Review Conducted with Follow-Up for Identified Issues for the SNF QRP as a resident-assessment based, cross-setting quality measure to meet IMPACT Act requirements with data collection beginning October 1, 2018 for the FY 2020 payment determinations and subsequent years.

AHCA appreciates the need for a drug regimen review and medication reconciliation in reducing unnecessary rehospitalizations, preventable adverse events, and improving health care outcomes. AHCA supports a standardized process for evaluation of medication use across multiple care settings to improve safe transitions and care experience for the individual patient/resident. AHCA supports the desired outcome of reducing inappropriate polypharmacy and adverse drug events.

AHCA Detailed Recommendations:

- CMS should not use this measure to meet the IMPACT SNF QRP domain of medication reconciliation. CMS should develop a medication reconciliation measure as required by IMPACT.

- CMS should seek NQF endorsement of this measure before finalizing since it does not meet IMPACT domain as a medication reconciliation measure, and therefore does not need to be specific under the IMPACT time frames for medication reconciliation measure.
If CMS decides to use this measure, CMS should define potential clinically significant in a manner that aligns with the definition in the CMS State Operations Manual for SNFs.

If CMS decides to use this measure, CMS should allow existing drug regimen reviews per requirements in SNFs to count in this drug regimen review measure.

CMS should provide evidence of robust testing of this measure since the MAP meeting in December 2015.

CMS should provide detail as to how this measure was continued to be refined since the MAP meeting in December 2015.

CMS did not address all the feedback and recommendations from the NQF MAP in the NPRM.

CMS should make reporting of this measure available to SNFs in real time through the CASPER Quality Measures report in QIES ASAP system.

AHCA recognizes the importance of medication reconciliation and supports standardized assessment and standardized measurement of this important area. CMS states in the proposed rule, “Valid, reliable, and relevant quality measures are fundamental to the effectiveness of our QRP.” For these reasons, AHCA does not support the use of this measure under IMPACT, medication reconciliation domain. This measure has not proven to be valid, reliable or relevant to medication reconciliation. The measure reflects drug regimen review, not medication reconciliation.

CMS states in the proposed rule, “For this proposed quality measure, a drug regimen review is defined as the review of all medications or drugs the patient is taking to identify any potential clinically significant medication issues.” CMS also states, “This proposed quality measure utilizes both the processes of medication reconciliation and a drug regimen review, in the event an actual or potential medication issue occurred.” The specifications of this measure only address drug regimen review, not medication reconciliation. In another measure for hospitals, CMS defines medication reconciliation as “The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.” This drug regimen review measure does not address medication reconciliation as defined by CMS. The MAP also raised this concern and requested greater clarity on how drug regimen review meets IMPACT requirements for medication reconciliation measures domain. This proposed measure does not address the MAP concerns and recommendations.

CMS states, “Of note, drug regimen review in PAC settings is generally considered to include medication reconciliation and review of the patient’s drug

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regimen to identify potential clinically significant medication issues.“ CMS uses Ibid reference for this, which refers to an article from the Journal of the American Geriatric Society that does not address this topic. The above statement from CMS does not accurately depict drug regimen review in PAC settings. Failure to recognize the difference between drug regimen review and medication reconciliation undermines the important and essential role of medication reconciliation in supporting patient safety.

This measure does not meet the requirement of IMPACT medication reconciliation, thus CMS should not proceed with using this proposed measure under IMPACT. In addition, this measure has not been adequately tested and, thus, is not ready to be included in the final rule.

If CMS proceeds with using this drug regimen review measure, the Agency needs to address how the current medication regimen review requirement for SNFs, as reflected in the SNF Requirements of Participation and SNF State Operations Manual §483.60(c) Drug Regimen Review, relates to this drug regimen review measure. CMS should acknowledge the existing drug regimen review requirement and allow for those reviews to be counted in this drug regimen review measure for SNFs.

The SNF PPS Proposed Rule references National Quality Forum Measure Applications Partnership (MAP) recommendations for this measure. These recommendations state regarding Medication Reconciliation: “Commenters agreed about the importance of the Drug Regimen Review Conducted with Follow-Up for Identified Issues-Post Acute Care measure, but expressed concerns about key terms lacking clear definitions and administrative burden associated with the measure. Commenters encouraged robust testing of this measure and reconsideration before it is finalized and implemented in the respective PAC/ LTC programs. The Proposed Rule also states, Since the MAP’s review and recommendation of continued development, we have continued to refine this proposed measure in compliance with the MAP’s recommendations.”

The current measure specifications do not provide a definition for the key term potentially clinically significant. There is no evidence of robust testing of this measure since the MAP met on December 14 and 15, 2015. CMS does not specify how it has continued to refine this proposed measure. Details on CMS actions from the MAP recommendations are important to understand how this measure has been refined, and evidence of robust testing is important to support acceptance of the validity of this measure.

AHCA understands CMS will provide definitions for the terms associated with this measure in future assessment manual instructions. AHCA recommends CMS align the definitions, particularly clinically significant and drug regimen review, with the definitions in the CMS State Operations Manual for SNFs.

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CMS proposes to report this quality measure to SNFs quarterly to facilitate internal quality monitoring and quality improvement in areas such as resident safety, care coordination and resident satisfaction. AHCA recommends CMS make the reporting of this measure available to SNFs in real time through the CASPER Quality Measures report in QIES ASAP system. Real time data is most useful in QAPI approaches and proactive performance improvement processes.

B8. SNF QRP Quality measures and Measure Concepts Under Consideration for Future years.

AHCA supports the future consideration of existing short stay quality measures as part of the SANF QRP program. AHCA also recommends that CMS modify its current development and review process for seeking public input on SNF QRP measures as already outlined above in our comments to B2. General Considerations Used for Selection of Measures for the SNF QRP.

With respect to the “transfer of health information” and “care preferences when an individual transfers,” AHCA recognizes that this is a requirement of IMPACT Act. The type and quality of information is extremely important to the individual patient’s care and outcomes. Therefore, this measure requires input from consumers, providers and health professionals with adequate pilot testing before finalizing in rule making.

With respect to the “residents who self-report moderate to severe pain,” AHCA provides the following comments and recommendations. AHCA supports both the NQF priority of patient and caregiver centered care and effective pain management and prevention. Experience of pain is an important and relevant aspect of patient and caregiver centered care. However, this specific measure is not the most appropriate or applicable to best measure patient centered care of pain. As the MAP noted, this measure does not address pain management. Rather, it captures only pain level and frequency. Management of pain is of critical importance to an individual, which this measure does not provide. Pain goals and thresholds are unique to each person. A measure that reflects whether the individual’s pain was appropriately addressed and effectively managed in their experience is more relevant, appropriate, and applicable to patient-centered care.

AHCA Detailed Recommendation:
- **CMS should develop a measure that reflects patient centered care pain management.**

With respect to the self-care and mobility measures, AHCA provides the following comments and recommendations. As stated earlier in our comments, AHCA has consistently and strongly encouraged the application of meaningful measures of outcomes related to function in PAC settings, including SNF. Most beneficiaries require facility-based SNF care because as a practical matter, they are unable to function safely at home while recovering from a health event. Therefore, function and not medical condition is typically the key driver of SNF care. Additionally, research has demonstrated that prior function and function at admission are the strongest predictors of PAC utilization and outcomes.
As such, AHCA considers measures of mobility and self-care measures to be of the highest importance and relevance to be added as SNF QRP measures. This is important enough to AHCA that we developed and maintain two NQF endorsed measures for SNF for mobility and self-care.

With regards to the appropriateness and applicability to SNF of using the four mobility and self-care measures listed in Table 13, we are currently evaluating these measures currently endorsed for the IRF setting (NQF # 2633, 2634, 2635, and 2636) as part of the CMS measure development TEP process. We will submit detailed comments through that process. We are particularly interested in exploring the patient self-reported prior function items included in the IRF measures for application as items in a SNF measure. However, of greatest importance to AHCA regarding a potential repurposing of the current IRF outcomes measures for mobility and self-care is that is that the individual function items are comparable across PAC settings and that the SNF-specific measure specifications are first tested in the SNF setting prior to being proposed for use in the SNF QRP.

With respect to the “seasonal Influenza vaccine” proposed measure, AHCA provides the following comments and recommendations. AHCA supports the addition of this measure. CMS may also want to add a pneumococcal vaccine measure as well. As measures that require the administration of a new service are added to short stay, AHCA recommends that CMS give due consideration to the cost of these services and the appropriateness of adding the measures when the costs of these services are bundled into the SNF Part A payment rates. The addition of such short stay measures, without an adjustment to the SNF Part A payments to account for the delivery of the service (e.g. the purchase of the vaccine) equates to a proposing a SNF Part A payment cut via proposing a quality measure that is part of payment determinations.

With respect to the “antipsychotic medication” measure, AHCA provides the following comments and recommendations. This antipsychotic measures has been in use for the past several years. AHCA appreciates CMS efforts to expand this measure to other settings, including hospitals, since a majority of the nursing home residents on these medications had them upon admission. We also, in general, support the measure including most individuals regardless of dementia diagnoses. However, we believe that FDA approved diagnoses and uses of the medication should be excluded. As recommended by the NQF MAP and others, bipolar disorder is an FDA approved diagnosis for the use of antipsychotics and should be an exclusion, but it is not. CMS is considering excluding bipolar in the recently hospital proposed. Therefore, we recommend CMS add bipolar disorder as an exclusion to this measure.

**AHCA Detailed Recommendations:**

1. CMS should add bipolar disorder to the list of exclusions for the antipsychotic use measure.

AHCA also recommends that CMS consider some additional measures for future inclusion in the SNF QRP program. In particular, consumer satisfaction following
short stay rehabilitation and discharge home. A short stay satisfaction measure, the CoreQ for discharges, is currently under review by the NQF for endorsement. This is a four item questionnaire developed by Nick Castle at the University of Pittsburgh.

**B9. Form, Manner, and Timing of Quality Data Submission**

**a. Participation/Timing for New SNFs** – *No comment*

**b. Finalized Data Collection Timeliness and requirements for the FY 2018 Payment Determination and Subsequent years** – *No comment*

**c. Data Collection Timelines and Requirements for the FY 2019 payment Determinations and Subsequent years**

CMS proposes to adopt calendar year data collection timeframes, following the initial three-month reporting period from October 1, 2016 to December 31, 2016 for all measures finalized for adoption into the SNF QRP. CMS also proposes a data collection period and data submission deadlines affecting the FY 2019, FY 2020, FY 2021 payment determination and subsequent years – with calendar year reporting and quarterly deadlines following a period of approximately 4.5 months of time to enable the correction of such data. For claims-based measures, CMS proposes to use one year of claims data beginning with CY 2016 claims data to inform confidential feedback reports for SNFs and CY 2017 claims data for public reporting.

AHCA supports CMS proposed adoptions in this section. AHCA recommends CMS continue with only one annual update to the MDS/RAI manual due to the significant implications placed on SNFs with each manual update.

**AHCA Detailed recommendation:**

- *AHCA supports CMS proposed adoptions in this section.*
- *AHCA recommends CMS continue with only one annual update to the MDS/RAI manual due to the significant implications placed on SNFs with each manual update.*

**d. Proposed timeline and data submission mechanisms for claims-based measures proposed for the FY 2018 payment determination and subsequent years.**

Background: CMS proposes to use one year of claims data beginning with CY 2016 claims data to inform confidential feedback reports for SNFs, and CY 2017 claims data for public reporting.

**AHCA Detailed Recommendation:**

- *CMS should change the proposed frequency of claims based measures update to every six months versus annual.*

**e. Proposed timeline and data submission mechanisms for claims-based measures proposed for the FY 2020 payment determination and subsequent years.**
Background: CMS proposes the following for FY 2020 payment determination: SNFs submit data on the proposed assessment-based quality measure for residents who are admitted to the SNF on and after October 1, 2018 and discharged from SNF Part A covered stays (that is, both residents discharged from Part A covered stays and physically discharged) up to and including December 31, 2018, using the data submission schedule that is proposed in this section. CMS proposes SNFs would have an additional four and a half months to correct and/or submit their quality data, and the final deadline for submitting data for the FY 2020 payment determination would be May 15, 2019. FY 2021 payment determination and subsequent years will collect data using the CY reporting cycle as previously noted.

AHCA Detailed recommendation:

- AHCA supports CMS proposed approach as it is consistent with other SNF QRP assessment-based measures.
- AHCA appreciates CMS recognition of data collection timeline to remain consistent with the usual October release schedule for the MDS.

B10. SNF QRP Data Completion Thresholds for the FY 2018 Payment Determination and Subsequent Years – No comment

B11. SNF QRP Data Validation Requirements for the FY 2018 Payment Determination and Subsequent Years

AHCA agrees with CMS that it is important to validate the accuracy of the data comprising quality measures being used to implement the IMPACT Act.

While AHCA agrees with CMS’s plan to do this, AHCA cautions CMS to approach the validation reasonably and realistically. Our concern comes from several experiences AHCA has had involving cynical views by media and others about nursing home data reporting behavior based on infrequent and rare, anecdotal reporting issues in the MDS data. Any data collection process will rarely if ever yield 100 percent accuracy. To require such would be unreasonable and promote the fabrication of data. We do not support random MDS audits by untrained surveyors and using the results in the survey process.

AHCA Detailed Recommendations:

1. AHCA recommends that CMS explore a combination of pure data checks to identify logical inconsistencies that exist between items relevant to the QRP measures and other items in the MDS, and to identify patterns of reporting that, with a high probability, may indicate incorrect reporting of data.

For example, a patient indicated as being in a coma should not be experiencing falls. Although the QRP data exclude coma patients from the denominator, if the SNF is reporting assessments with that pattern, then that strongly suggests a data accuracy problem. Similarly, patients who are free of pressure ulcers should tend to have higher functional independence scores than patients who have severe pressure ulcers. If in a center functional independence does not vary depending on the presence of pressure ulcers, then that suggests a potential data accuracy problem.
problem. Results of these audits should be provided as part of the SNF feedback reports on the quality measures so they can be used to improve data accuracy.

2. **AHCA recommends that CMS audit suspicious data patterns using specifically trained MDS experts and provide results back to the SNF for quality improvement purposes rather than citing the facility through the newly-established focus survey program.**

For those SNFs with persistent problems with data accuracy that have not improved after receiving feedback reports based on MDS logic algorithms, CMS should conduct a review of the MDS records. This would allow CMS to review whether the ‘red flags’ identified in the data checks are indeed reflective of incorrect MDS data reporting behaviors, which may be intentional or innocent. It also will utilize a proven approach to improve data accuracy in the context of quality improvement rather than a purely punitive approach.

3. **AHCA recommends that CMS present a list of validation checks to providers and MDS vendors to help improve accuracy of data.**

Providing such data will allow providers to ensure policies and procedures, as well as vendors, to incorporate data checks into MDS to help improve the data accuracy. Without specifying the information to providers, data accuracy will improve haphazardly and more slowly, and undermine the validity of the SNF-QRP data.

4. **CMS should work with existing data analytic vendors and electronic medical record (EMR) vendors who have developed robust data accuracy checks for inconsistent coding in the MDS.**

Many data analytic vendors and EMR vendors have built data logic tests similar to those outlined above in our first recommendation. CMS should work with these vendors to identify and standardize these practices across the entire setting. This will help improve the accuracy of MDS data and increase the public’s confidence the data reflects the care and outcomes patients experience during their SNF stay.

**B12. SNF QRP Submission Exception and Extension Requirements for the FY 2018 Payment Determination and Subsequent years – No comments**

**B13. SNF QRP Reconsideration and Appeals Procedures for the FY 2018 Payment Determination and Subsequent years – No comments**

**B.14 Public Display of Quality Measure Data for the SNF QRP & Procedures for the Opportunity to Review and Correct Data and Information**

CMS proposes procedures to allow individual SNFs to review and correct their data and information on IMPACT Act measures that are to be made public before those measure data are made public.

**AHCA Detailed Recommendations:**

- **CMS should provide SNFs with real time reporting for the assessment based measures through the CASPER Quality Measures report in the QIES ASAP system.**
CMS should change the proposed frequency of claims based measures update to every six months versus annual.

AHCA supports CMS proposed approach of providing SNFS with confidential feedback report, review and correction period and preview period. AHCA supports CMS’s plan to report through QIES ASAP system in CASPER Quality Measures report, including both facility and resident level detail.

AHCA recommends real time reporting for the assessment based measures. Real time data is most useful in QAPI approaches and proactive performance improvement processes.

AHCA supports CMS’s plan to use a 90 day run out period for claims based measures in order to provide data as timely as possible. AHCA recommends CMS update the claims based measures every six months using a rolling calendar year to calculate the rates. More frequent updates will make the data from these measures more relevant to current practice for SNFs and enable SNFs to incorporate performance on these measures into QAPI efforts. Updates every six months versus annually will also provide more current information to consumers.

Section B.15 Mechanism for Providing Feedback Reports to SNFs

CMS proposes to make the confidential feedback reports available to each SNF using the CASPER system in QIES ASAP. Data contained within these CASPER reports would be updated, as previously described, on a monthly basis as the data become available except for claims-based measures which can only be previewed on an annual basis.

AHCA Detailed Recommendations:

- CMS should provide SNFs with real time reporting for the assessment based measures and every six months reporting for claims based measures.

AHCA supports CMS plan to make the feedback reports available in QIES ASAP through CASPER. AHCA recommends as noted in prior sections of our comments, that CMS provide real time reporting for assessment based measures and every six months reporting for claims based measures.

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Section 6: Payment Models Research

AHCA supports efforts to modernize and improve the efficacy and efficiency of the SNF PPS. To support a dialogue with CMS, the Association has invested considerable time and resources to conduct in-depth therapy and NTAS research to aid in reforms to the existing PPS. Below, we offer a description of the scopes of work:

1. Non-Therapy Ancillary Services (NTAS). To-date, no primary Part A drug data has been collected for purposes of analyzing NTAS costs and implications for the nursing component. AHCA has collected primary data directly from 10 long term care pharmacies, including two large, national pharmacies. In turn, a database was developed, and AHCA is analyzing the data.

2. Therapy Services. The purpose of the work is to conduct analyses of Medicare Part A therapy component utilization to identify areas that merit more in-depth work. The research compares SNF subpopulations, examining utilization, certain outcomes, Medicare payments, and length of stay.

AHCA would be pleased to share this research with both CMS and, as CMS deems appropriate, its Payment Models Research contractor. Additionally, the Association has developed a SNF payment reform concept aimed at aligning the SNF payment system with other PAC payment systems. AHCA believes such a step will aid in the development of the IMPACT Act-mandated unified, cross PAC-setting payment system. In regard to CMS’s current SNF PPS effort, we offer an overview of the Association’s vision for PPS redesign below, as well as important considerations such as the value-based purchasing program (VBP) and quality reporting program (QRP), data sources, and the Association’s perspective on TEP discussions.

PPS Redesign Framework. Conceptually, AHCA believes PPS Payment Reform should address a broad range of issues and not be comprised of an array of incremental changes which may or may not produce the desired results. Specifically, we believe the goals of SNF PPS Payment Reform should be to: 1) address the needs of patients regarding therapy, with particular attention paid to patients whose care is primarily acute or medical in nature, patients with chronic care needs who may require long term care, and patients who require high levels of rehabilitation, while concurrently preserving funds to ensure access for people who are medically fragile; and 2) achieve short-term stability; and 3) lay the foundation for longer term reform as IMPACT Act Payment Reform work unfolds.

AHCA believes the approach should include the following elements which would, in turn, support the goals the Association has articulated, above:

- Strategies to make the SNF PPS a more patient-centered payment system.
- Flexibility in delivery of care based upon patient plans of care in order to increase efficiencies, as long as outcomes are produced.

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6 In its 2006 report entitled, “Modeling Alternative Designs for a Revised PPS for Skilled Nursing Facilities” CMS discusses grouping patients into acute, chronic and rehab care categories (e.g., New Profiles).
7 Restructuring assessment for and delivery of therapy would need to accommodate patients who require ongoing maintenance therapy a la Jimmo.
• Quality reporting that serves as a key basis for change.

AHCA also believes socioeconomic status (SES) should be considered as part of the research as it relates to quality reporting and measurement. Specifically, the Association concurs with MedPAC’s statement that “a better way to address any differences in outcomes is to compare rates (of spending) that have not been adjusted for SES across “peer” providers that have similar shares of, for example, low-income, beneficiaries.” This way, the outcome rates remain intact, but the comparisons are ‘fair’ because providers are compared with other providers with similar shares of low-income beneficiaries.”

Payment Redesign Outcomes. Furthermore, AHCA believes SNF PPS payment reform should produce the following outcomes:

• Patient-Centered Payment – In the short-term, payment should be based upon patient-specific clinical needs. Such experience should be used to lay the foundation for the IMPACT Act-mandated cross-setting, unified PAC payment system.
• Appropriate Utilization – Encourages appropriate utilization of SNF services by more closely aligning reimbursement to a patient’s clinical complexity.
• Staffing – Improves efficiency through better understanding of patient acuity and reimburses sufficiently to attract and retain qualified staff.
• Care Transitions – Improves ability to target resources toward higher acuity patients that will have the most difficulty transitioning to other settings of care.
• Stability – Provides legislative and regulatory stability to the SNF payment system.
• Patient Placement – Encourages providers to care for higher acuity patients by better aligning costs and payments.

PPS Reform Should Account for New SNF Requirements. AHCA believes any payment reform initiative should recognize at least three significant, new SNF program requirements. First, on July 16, 2015, CMS promulgated Medicare and Medicaid Programs, Reform of Requirements for Long-Term Care Facilities, Proposed Rule, Federal Register, Vol. 80, No. 136, CMS-3260-P. Many of the updated and/or new provisions entail new provider operational costs. Below, we highlight a few key areas of concern which make ensuring payment is accurate critical:

3. Array of Changes at Once. There are numerous changes and increased requirements in the proposed rule. Some of these include:

• Quality Assurance and Performance Improvement (QAPI) plan development
• Compliance and Ethics program
• More extensive Infection Control requirements

8 MedPAC comment letter on SNF PPS NPRM FY 2017 accessed on May 25th.
A required facility assessment that will be used to determine “sufficient staff”
- Requirements related to behavioral health services
- Determining staff competency
- Credentialing of residents’ attending physicians
- Employees and contracted direct care, nursing service and food and nutrition service staff are expected to meet competency, knowledge and skill requirements
- Additional training requirements for all new and existing staff, individuals providing services under contractual arrangement, and volunteers, consistent with their expected roles
- Utilization of culturally competent, trauma-informed approaches to care for patients/residents

AHCA concerns: There are many new requirements all at one time. AHCA has recommended these be phased-in over five years with compliance required one-year post phase-in of individual requirements. The cost of implementation is not covered by Medicaid or Medicare.

4. Transitions of Care. Transfer or discharge must be documented in the resident’s clinical record and appropriate information communicated to any receiving setting, including home with home health services, hospice setting, assisted living, etc. Documentation includes 18 specific items that must be included (p. 42255). When the resident is being transferred for the resident’s safety and welfare, in addition to the previously mentioned 18 items that must be documented, the center must document the specific resident needs it cannot meet, the center’s attempts to meet the needs, and the services available at the receiving facility that will meet the resident’s needs (p. 42189-42190; 42255).

AHCA concerns: This may result in the need for additional staff resources within a center that are not covered by Medicare or Medicaid.

To view AHCA’s list of key concerns with the proposed RoPs, click here. For purposes of our comments on our payment rule, again, we urge CMS work closely with the profession to ensure payment is accurate and sufficient to address these new federal requirements associated with Medicare program participation.

The Association will continue to support quality efforts through our Quality Initiative, collaborative work with CMS, and liaison with Congress.

Any PPS payment redesign effort must consider the implications of the new VBP and QRP programs. These new programs will impact provider behavior and have reimbursement implications, as well. Specifically, going forward, Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) added new subsections (g) and (h) to section 1888 to the Social Security Act (Act). The new Subsection 1888(h) authorizes establishing a SNF VBP Program beginning with FY 2019 under which value-based incentive payments are made to SNFs in a fiscal year based on performance. The incentive payments will be paid from a pool of dollars accrued through a 2 percent
withhold applied to all SNFs. Based upon their rehospitalization performance, SNFs may or may not earn back the withheld 2 percent or some portion of this. In addition to the withhold amount, referral patterns also will change based upon SNF performance.

Additionally, the Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185) (IMPACT Act), enacted on October 6, 2014, requires the implementation of an array of SNF QRP elements. Like the rehospitalization program, SNF performance on the QRP elements will impact referral and may have a financial impact if the provider is unable (or does not) report.

**Data Sources.** AHCA strongly recommends that IMPACT Act assessment data be used as part of the redesign effort. We caution against the use of only administrative data. Specifically, assessment data is key to understanding patient characteristics and any associated outcomes. Reliance on just administrative data will have limited value compared to the addition of clinical information from assessment tools. AHCA strongly believes payment model research must include clinical conditions beyond diagnoses such as functional status, cognition, and respiratory status.

**Conclusion.** AHCA appreciates CMS’s efforts with the TEPs. However, we also believe the work shared during the February 2015 Therapy TEP and the December 15 Nursing Component TEP both highlighted more questions and gaps in data than perhaps where anticipated. AHCA urges CMS to more fully address key questions from the TEPs before proposing a complete payment model redesign.
Section 7: Collection of Information Requirements

CMS does not believe the three claims based measures will result in any additional data collection burden since SNFs already file claims. The one MDS-based proposed measure (drug regime review) is also estimated by CMS to not have a substantial data collection burden and therefore meets exceptions to PRA provided in section 1899B(m). CMS estimates the new data elements will take 7.5 min of RN time to complete on all admissions and 2.5 min on all discharges. The standardization of these measures and associated collection is absolutely covered by the non-applicability provision of §1899B(m).

**(m) NON-APPLICATION OF PAPERWORK REDUCTION ACT. — Chapter 35 of title 44, United States Code (commonly referred to as the ‘Paperwork Reduction Act of 1995’) shall not apply to this section and the sections referenced in subsection (a)(2)(B) that require modification in order to achieve the standardization of patient assessment data.**

When the modification to MDS and other PAC assessment instruments have achieved standardization, the exemption provision will no longer apply at which point CMS will submit the requirement and associated burden to OMB, consistent with PRA.

Still, CMS lays out their estimate of burden, which we can refute and lay out our estimate. We are not sure it is worth the effort other than to say it has been completed.

AHCA disagrees with CMS’s assessment that the MDS-based measure does not result in data collection burden. It adds measures to MDS, training on staff, recoding MDS software, and installing and training on new software. Every change to the MDS, regardless of size, therefore increases costs to SNFs, which need to be considered in CMS cost impact analysis. This is why we have continued to advocate for changes to the MDS on a no more frequent basis than once a year. Congress agreed with this concern and specified in the IMPACT Act that assessments tools should not be modified more frequently than once a year.

CMS states, “We estimate the additional elements for the four newly proposed measures will take 7.5 minutes of nursing/clinical staff time to report data on admission and 2.5 minutes of nursing/clinical staff time to report data on discharge, for a total of 10 minutes.”

The CMS-estimated time of 2.5 minutes for coding the new MDS items on discharge is not accurate. The proposed new MDS item on discharge for Drug Regimen Review measure would require review of the entire stay to identify if the physician was contacted in a timely manner and recommended actions were completed in the specified timeframe each time potential clinically significant medication issues were identified since admission. This would be at least 20 minutes (or more) depending on the length of stay and extent of documentation necessary to review.

**AHCA Detailed Recommendations:**

a. Cost estimate does not include staff training.
b. Cost estimate does not include updates and reinstallation of MDS software.

c. Cost estimate assumes RN and Pharmacist have extra time available within their salary and will not result in overtime or need to hire additional staff.

d. CMS needs to adjust the estimated time for coding new MDS items on discharge for Drug Regimen Review measure from 2.5 minutes to at least 20 minutes.

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