AHCA
AMERICAN HEALTH CARE ASSOCIATION

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

August 25, 2017

Tom Coble
CHAIR
Elmbrook Management Company
Ardmore, OK

Michael Wylie
VICE CHAIR
Genesis Health Care
Kennett Square, PA

Robin Hillier
SECRETARY/TREASURER
Welcome Nursing Home
Oberlin, OH

Leonard Russ
IMMEDIATE PAST CHAIR
Bayberry Care/Aaron Manor Rehab
New Rochelle, NY

Greg Elliot
AT-LARGE MEMBER
AMFM, LLC.
Charleston, WV

Phil Fogg
EXECUTIVE COMMITTEE LIAISON/
AT-LARGE MEMBER
Marquis Companies
Milwaukie, OR

Deborah Meade
AT-LARGE MEMBER
Health Management, LLC
Warner Robins, GA

David Norsworthy
AT-LARGE MEMBER
Central Arkansas Nursing Centers, Inc.
Fort Smith, AR

Janet Snipes
AT-LARGE MEMBER
Holly Heights Nursing Center
Denver, CO

Phil Scalo
INDEPENDENT OWNER MEMBER
Bartley Healthcare
Jackson, NJ

Steven M. Cavanaugh
MULTIFACILITY MEMBER
HCR ManorCare
Richmond, VA

Gary Kelso
NOT FOR PROFIT MEMBER
Mission Health Services
Ogden, UT

Glenn Van Ekeren
REGIONAL MULTIFACILITY MEMBER
Vetter Health Services
Elkhorn, NE

Chris Mason
NCAL MEMBER
Senior Housing Managers
Wilsonville, OR

Dirk Anjewierden
ASHCAE MEMBER
Utah Health Care Association
Salt Lake City, UT

Peter Corless
ASSOCIATE BUSINESS MEMBER
OnShift, Inc.
Cleveland, OH

Mark Parkinson
PRESIDENT & CEO

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Re: AHCA Response to Advanced Notice of Proposed Rulemaking, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-Mix Methodology. Federal Register, Vol. 82, No. 85, May 4, 2017. CMS-1686-ANPRM

Dear Administrator Verma:

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represents more than 13,500 long term and post-acute care facilities, or 1.07 million skilled nursing facility (SNF) beds and more than 225,000 assisted living beds. With such a membership base, the Association represents the majority of SNFs and a rapidly growing number of assisted living communities.

AHCA agrees that the existing SNF prospective payment system (PPS) is problematic and should be modernized to keep pace with broader Medicare payment policy. We welcome the opportunity to work with the Centers for Medicare & Medicaid Services (CMS) on modernizing SNF payment. Furthermore, we appreciate CMS' use of the Advanced Notice of Proposed Rulemaking (ANPRM) vehicle for the proposed Resident Classification System (RCS) rather than the SNF PPS update rule. The use of an ANPRM allows CMS more flexibility regarding next steps with RCS. AHCA also greatly appreciates the 60-day comment period extension, the release of simulated payment data, and the related patient classification guidance to better inform our comments.

While we understand the ANPRM is intended to solicit feedback on a concept, we have deep concerns about advancing RCS without an in-depth and ongoing collaborative discussion about the underlying methods and assumptions, as well as possible implementation. Of more concern, we believe RCS would perpetuate certain current PPS problems while also creating new problems. For example, we believe RCS still would not mitigate access barriers for patients with high non-therapy ancillary service costs. Furthermore, reductions in payment to rural and Medicare low-volume

providers would perpetuate, if not exacerbate, existing access issues. In short, we do not view the current proposal as an improvement over the existing PPS other than addressing a single, but important issue – therapy utilization. Other than creating incentives to decrease therapy utilization, RCS simply would create more issues than improvements for beneficiaries, providers, and the Medicare program.

Underlying our concerns, and as we have shared with CMS' contractor Acumen, we do not believe the data and related analytics are sufficient to support the model. To arrive at this conclusion, AHCA has invested considerable resources in studying RCS and the underlying analytics. We also believe that the omission of critical policy initiatives in the proposed payment framework, such as the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) and the Requirements of Participation (RoP), is very troubling. Specifically, during the technical expert panels, Acumen repeatedly indicated that other laws for which CMS is responsible, as well as other CMS programs and projects, were "out of their scope." With respect, we do not believe CMS enjoys the same largesse in disregarding such laws, regulations, and projects which interact with SNF payment and operations.

During our early March meeting with you, we greatly appreciated your helpful observations on the cumulative effect of regulatory burden, both oversight and payment, on health care providers. RCS, which was completed under the previous Administration, falls far short of your priority and CMS' goal of a simpler operating environment for health care providers. RCS would result in new provider burden and a far more complicated payment system which, in turn, would result in more payment errors and more questions about payment accuracy. In short, RCS falls far short of a "simpler" payment system.

The Association offers these comments, while direct and assertive, collegially and in the spirit of collaboration. Our tone and level of detail are intended to convey the Association's concern that, as currently conceived and based upon available information, the RCS concept would not improve the existing PPS or aid CMS in aligning the SNF PPS with its overarching Medicare payment policy goals. As discussed in detail below and based upon available information, we are concerned that CMS would create new program integrity issues for Medicare, compliance challenges for providers, and new access issues for beneficiaries with RCS as currently conceived.

AHCA believes RCS contains many substantive, serious questions that need to be answered before it could be considered implementable. Due to these significant concerns, many of which are shared by sister provider associations as well as beneficiary groups, we urge CMS to commission a third-party peer review of all underlying research, programing, and related outputs before advancing the RCS concept as currently designed in any way. At the same time, AHCA understands the need to advance a payment reform effort. To that point, AHCA would gladly work with CMS on the collection of patient characteristics data directly from SNFs rather than using hospital data to design the system. We also would be pleased to work

with CMS to improve cost reporting data. Such improved information would lay the foundation for a more viable payment system proposal.

In conclusion, again, we offer these comments constructively and collegially. AHCA is eager to schedule time for our members, staff, and researchers to speak with CMS staff to provide an in-depth explanation of our work and to discuss how we collectively could achieve CMS' goals associated with a new SNF payment system. To schedule such a meeting, please contact Mike Cheek at mcheek@ahca.org.

Sincerely,

Mark Parkinson
CEO/President

CC: Demetrios Kouzoukas
Carla DiBlasio
Brady Brookes
Laurence Wilson
Jeanette Kranacs
Todd Smith
John Kane

Table of Contents

Executive Summary

AHCA supports efforts to modernize and improve the efficacy and efficiency of the SNF PPS. As such, the Association has invested considerable time and resources to conduct in-depth analyses on RCS. In response to CMS' request for feedback on the viability of RCS to replace the existing SNF PPS (page 22098 of the ANPRM) and for the payment system design, we offer the following commentary on RCS capacity to meet CMS goals (as requested on page 220984):

- ***Payment Accuracy.*** AHCA agrees that payment accuracy should be a core premise of any payment reform effort. Additionally, we respect CMS' need to utilize available data. However, use of dated data, STRIVE methods from 2006, and a one-year snapshot from 2014 – without any testing across other years for stability or looking at how rates might change with new data – raises serious questions about both the RCS design as well as its stability. We are concerned about CMS program integrity issues, provider compliance challenges, and beneficiary access issues, which will result from such a limited, static analysis.

- ***Incentives to Deliver Therapy.*** AHCA agrees the current PPS does not appropriately represent the needs of medically complex patients. However, we are concerned that the proposed structure for distribution of therapy component dollars will not improve payment accuracy for therapy due to serious questions about underlying assumptions and methodology. Specifically, we believe RCS would create barriers to accessing Speech Language Pathology and distribute payment based on condition categories that do not accurately reflect actual reasons for SNF care. It also lacks guardrails to prevent stinting on therapy, such as strong links to outcome measurement – in fact, RCS-1 would not at all further the agency's goal of shifting payments from volume to value.

- ***Simplification.*** RCS is far more complex than the current PPS without any evidence that it would improve care. It would require more staff time and resources aimed at bureaucratic processes to ensure payment rather than delivering patient care. Specifically, in its discussion of RCS, CMS asserts that the proposed system would reduce burden by reducing the number of MDS assessments. However, regular MDS will continue to be required to comply with the Requirements of Participation Comprehensive Person-Centered Care Plan requirement. Additionally, other notable new costs include: repurposing and training staff, such as MDS coordinators and therapists; billers and hiring additional staff with health care coding expertise and certification (e.g., SNFs currently do not have such expertise in-house); and expanding physician relationships to validate diagnoses.

Alignment with Broader Medicare Payment Policy. While not a CMS goal for RCS, AHCA believes such an effort should align with other Medicare payment policy initiatives. CMS indicates the patient characteristics basis is what aligns RCS with Medicare payment trends. First, as discussed below, we believe CMS has accepted flawed patient characteristics research from its contractor. Second, no discussion of the rest of Medicare or post-acute reform is included nor any discussion of how RCS would be updated. All other payment systems include updating features, including annual re-basing of hospital payment. Specifically, the hospital DRG-based payment system regularly is updated to account for changes in patient mix, clinical practice, and medical service costs. RCS appears to be static, essentially freezing SNF payment policy in the past (e.g., 2006 and older data and assumptions) with no provision for modernization and updates. Third, while we respect MedPAC's observation that RCS aligns with their view of a patient characteristics based unified post-acute care (UPAC) payment system, we note that CMS still is proposing a per diem payment system with no supporting companion policies. MedPAC's UPAC PPS concept is stay-based and includes companion policies to ensure more accurate payment.

In terms of our detailed comments, we have crafted the following sections and related key statements:

A. Statistical Methods and Data Sources. The Association respects CMS' priority to move forward quickly with available data to address pressing challenges with the existing PPS. However, AHCA also believes assumptions based upon weak and/or flawed statistical methods as well as antiquated and/or dated data sources have resulted in a highly unstable payment system design that places both quality outcomes and provider financial stability at risk. An AHCA commissioned analysis raises serious questions about: 1) RCS design integrity; and 2) system performance once moved beyond a research project to a real-world payment system which will drive patient care (see Section 1: Independent Statistical Critique). **Comment:** *CMS should commission an independent Peer Review Critique of Statistical Methods and Assumptions.*

B. Patient Characteristics. Following the June Technical Expert Panel (TEP), in response to TEP participant concerns about Acumen assumptions about the foundational patient characteristics, Acumen produced a patient characteristics study. AHCA found many of Acumen's findings in this document very disconcerting. Specifically, Acumen found decreases in the prevalence of dementia in SNFs and little to no change in patient mix between 2006 to-date. In turn, the Association commissioned an independent study using claims and MDS data. Those results conflict with Acumen's findings and raise serious questions about data and methods used to develop the RCS patient classifications and how patients might be classified in a real-world environment (see Section 2: Patient

Characteristics). **Comment:** *In preparation for a systems redesign, CMS should collect patient characteristics data directly from SNFs rather than using hospital data to design the system. It also is important that any payment system based on a research project using old data both include re-calibration and self-correcting mechanisms, and improve data collection to support self-correction – currently there is no discussion of such processes. Furthermore, RCS does not acknowledge the new data mandated by the IMPACT Act which could be useful in future re-calibration. Improved data collection can always be incorporated into annual rule making to move the system towards data that accurately captures change in case mix and clinical practice.*

C. CMS Authority and Responsibilities. In this section, we discuss an array of laws, CMS regulations, and CMS demonstrations which should be assessed as part of any SNF payment system proposal development. CMS has not incorporated the interactive impacts of RCS and these related laws and regulations on providers, provider behavior, and impacts on beneficiaries (see Section 3: Assessment of CMS Authority and Responsibility). **Comment:** *As part of the independent peer review, the contractor should be directed to include in their analysis laws, regulations, and other payment system impacts on the proposed SNF payment system.*

D. Compliance and Program Integrity. As discuss above, RCS complexity is daunting, and the ANPRM offers little detail on how the payment system would be operationalized and overseen. Based upon the ANPRM conceptual information, RCS would substantially increase CMS' program integrity challenges, provider compliance burden and create new challenges with ensuring high quality patient care – AHCA's core mission. For example, we remain concerned about access to maintenance therapy. Additionally, AHCA is concerned about gathering accurate and timely patient classification information. Specifically, ICD-10 diagnosis coding is not heavily practiced in SNFs, and without CMS guidance, considerable challenges would arise with reconciliation and variation in coding (see Section 4: Compliance and Program Integrity). **Comment:** *We urge CMS to engage the SNF profession and other SNF-related stakeholder groups in a dialogue about these very serious issues well before any implementation effort begins. In the absence of such a dialogue, we believe CMS is creating new SNF payment issues, as well as beneficiary access challenges.*

E. Beneficiary Protections. AHCA also is very concerned about the absence of any discussion of beneficiary protections. Our key concerns are: a) access to therapy; and b) premature discharges due to untested payment system incentives to shorten

lengths of stay. Additionally, due to underlying challenges with CMS assumptions about patient characteristics and related clinical practices, we also are concerned providers' ability to produce outcomes for patients. Finally, it is unclear what changes CMS will make to beneficiary appeals processes when it appears beneficiaries are "locked" into classifications based upon diagnosis or no longer qualify for an administrative presumption of coverage (see Section 5: Beneficiary Protections). **Comment:** *We request that CMS provide a detailed discussion of how beneficiary care would be ensured and how it plans to maintain beneficiaries' ability to voice concerns about care in a manner that allows care delivery to be adjusted during the stay, not following discharge. We urge CMS to engage the SNF profession and other SNF-related stakeholder groups in a dialogue about these very serious issues well before any implementation effort begins. In the absence of such a dialogue, we believe CMS is creating new beneficiary access challenges.*

F. ***Implementation.*** RCS is a not an update to the SNF PPS; it would be a new SNF PPS. The original SNF PPS was based upon several demonstrations, years of testing, and an ongoing, transparent dialogue between CMS and the SNF profession. We believe considerable time and interactive discussion will be needed to develop operational guidance and procedures, update information collection and transmittal tools, including new software and programming to support RCS, and considerable provider training (see Section 6, sub-section A: Implementation & Timeline Considerations). **Comment***: In response to CMS' inquiry regarding operationalizing and transitioning to the new system, AHCA envisions an equally rigorous process for testing as well as open and ongoing CMS and SNF profession discussions before such plans are finalized.*

G. ***Market Basket and Wage Variation.*** AHCA 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. **Comment:** *The Association believes the Chief Actuary has the authority to take such steps at the CBSA level.* Over the years, AHCA has commented often on the need for a more accurate and appropriate approach to a SNF wage index. In terms of geographic variation in wages, the Association has prepared an approach which trims the hospital data to labor categories, better aligning with SNF categories (see Section 6, sub-section B: Market Basket Updates and Wage Variation). **Comment***: The Association believes this approach aligns with CMS' preferred approach to rely upon hospital data, but offers a more accurate SNF wage index methodology.*

H. Component Design. While AHCA has long supported the notion of certain component changes, specifically the creation of a stand-alone non-therapy ancillary services (NTAS) component, we are troubled by several underlying component design assumptions and the lack of important companion policies, which are included in other PAC payment systems as well as MedPAC's UPAC Payment System prototype. Additionally, CMS has long had an overarching goal to reduce fragmentation in payment and health care delivery. However, the RCS proposal would further complicate payment. We believe there are serious challenges with the components (see Section 6: Section-by-Section Comments). **Comment***: The data and assumptions associated with component design all should be revisited by the third-party reviewer.*

I. MDS Schedule and Operations. AHCA appreciates CMS' efforts to reduce SNF administrative burden by reducing the number of MDS required under the current payment system. However, in a real world operating environment, multiple MDS would continue to be required due the Requirements of Participation (i.e., Comprehensive Person-Center Care Planning), mid-stay re-classifications, now conceptualized as using the Significant Change in Status Assessment, and a redesigned Discharge Assessment. While the number of assessments might be decreased for some patients, the time required to complete any new MDS under RCS will require far more clinical input and scrutiny than in past. Additional clinical information will be required and must updated in ways which currently are not required. Additionally, as we discuss in our components section, as well as in the MDS and Operations Section, we believe considerable new administrative staffing would be required for RCS and we question whether RCS adequately accounts for the nursing care needs of today's patients and an increasingly medically complex patient mix (see Section 6, sub-section E: MDS Schedule and Operations). **Comment:** *AHCA strongly believes CMS should conduct an assessment of RCS assessments, RoP required assessments, and should revisit its assumptions about operational costs associated with delivering care to an increasingly medically complex population.*

J. Administrative Presumption. AHCA understands that CMS exploring adaptations to the current administrative presumption policy under RCS-1. Specifically, CMS is considering continuing the administrative presumption for those included in one of the 43 existing non-rehabilitation RUG-IV groups that are being carried over to the RCS-1 model. Under RCS-1, the administrative presumption would continue to apply to those of the 43 groups that comprise the designated nursing categories under the existing RUG-IV model (see Section 6, sub-section F: Administrative Presumption). **Comment:** *AHCA supports the notion that the administrative presumption policy is important and would need to be updated to reflect the*

different case-mix methodology approaches between the current RUG-IV payment model and the RCS-1 payment model. We believe that the current approach under consideration is inadequate to protect resident access.

K. Impact Analysis. AHCA compared the facility level impact analysis released recently with the CMS Public Use File SNF facility level data. This comparison raised serious concerns regarding the representativeness of the data used to design RCS-1, indicating a high probability that the distributions of patient characteristics and payment level estimates and relativities are going to be biased. This bias would affect potential access for certain types of patients not adequately addressed by RCS-1 (i.e., disabled, high HCC risk scores, bariatric, etc.). This bias will also affect some classes of SNF, putting them at a serious disadvantage. The methodology for the impact analysis is only described minimally, and a robust explanation is needed to provide further evaluation. The comparison of the RCS-1 results to the PUF data for the same time period, however, illustrates a very different result than suggested by the overall impact analysis. CMS does not take into consideration the variation in the types of SNFs or the large number of low-volume Medicare SNFs (see Section 6, sub-section G: Impact Analysis). **Comment:** *AHCA questions whether the impact analysis as accurate, and is deeply concerned about the lack of representativeness. The resulting bias suggest specific areas in which the RCS-1 assumptions and patient characteristic classification structural elements fail to accurately account for many SNF patients. Until these concerns are fully addressed, we are concerned that RCS-1 would lead to significant potential access barriers. The use of a single year of data and the fixed nature of the proposed system also threatens greater misrepresentation of the changing SNF population served in 2017 and into the future.*

L. Budget Neutrality. AHCA believes budget neutrality would be critical with RCS. We are concerned about the analytic methods and data upon which RCS is based, reliance on a single year simulation and the unclear impacts on patient access to services. From the available detail, AHCA believes RCS would result in new patient access challenges. Also of concern are potential problems with Medicare program integrity. Finally, AHCA believes RCS would accelerate the current trend of increasingly high concentrations of patients with complex care needs in SNFs. At the same time, it is unclear if RCS would adequately cover the cost of care for providers particularly hospital-based, rural and low volume providers (see Section 6, sub-section H: Budget Neutrality). **Comment:** *We urge CMS to open an ongoing dialogue on RCS to address these and other concerns before advancing the proposal. A single day meeting or additional opportunity to comment only in writing will not be sufficient to address these challenges.*