



June 18, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1718-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on Proposed Rule, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2020; CMS-1718-P

Dear Ms. Verma:

LeadingAge appreciates the opportunity to provide feedback regarding the Fiscal Year (FY) 2020 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) proposed rule. We offer these comments in the spirit of collaboration and look forward to working with the Centers for Medicare & Medicaid Services (CMS) to ensure a smooth and successful transition to the revised payment system.

The mission of LeadingAge is to be the trusted voice for aging. Our over 6,000 members and partners include nonprofit organizations representing the entire field of aging services, 38 state associations, hundreds of businesses, consumer groups, foundations and research centers. LeadingAge is also a part of the Global Ageing Network, whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy and applied research.

Our comments below cover several sections of the proposed rule. For ease of interpretation, we have provided the name of the heading or sub-heading most closely related to the specific element on which we wish to comment.

SNF PPS

SNF MARKET BASKET UPDATE

LeadingAge is pleased to see the positive market basket update of 2.5% after the multifactor productivity adjustment. The estimated growth rate reflects the lived experience of our members that show rising costs to deliver high quality care. LeadingAge members are nonprofit that, according to MedPAC data on SNFs, have slim Medicare margins of 1.7% in 2017. We note that a reduction in Medicare rates as suggested by MedPAC could have devastating effects on nonprofit SNFs. **We ask that CMS consider the unique situation of mission-driven,**

nonprofit providers, who are and have been strong community partners for decades meeting the post-acute needs of a wide variety of older adults without profit motivation, in creating payment policy.

WAGE INDEX ADJUSTMENT

As noted in the proposed rule, CMS has utilized hospital inpatient wage data exclusive of the hospital wage index's occupational mix adjustment in developing a wage index for SNFs and proposes to continue this practice for FY 2020 in the absence of SNF-specific wage data. Noting the proposal in the Hospital Inpatient Prospective Payment System (IPPS) Proposed Rule (CMS-1716-P) to address wage index disparities between high- and low-wage index hospitals, we seek clarification from CMS on how the SNF wage index will be impacted in later years if the proposal in the IPPS rule is finalized. Will the disparities being addressed in the IPPS be part of the pre-reclassified wage data that drives the SNF wage index? SNFs are facing wage pressures that in some instances might be similar to the underlying issues that hospitals in their region face but, as indicated in the proposed rule, there are differences between hospitals and SNFs in both wage issues and geographical considerations. **We recommend that CMS examine disparities in the wage index for SNFs to determine if there are issues that need to be addressed.** The data presented in MedPAC's March 2019 Report to Congress show sizeable variation in Medicare margins between frontier, rural, and urban SNFs as well as the spread between those at the 25th compared to the 75th percentile of Medicare margins.

SNF LEVEL OF CARE – ADMINISTRATIVE PRESUMPTION

In the FY 2019 SNF PPS final rule, the case-mix classifiers for administrative presumption were updated for the Patient-Driven Payment Model (PDPM) with the intent “to review the new designations going forward and make further adjustments over time as we gain actual operating experience under the new classification model.” LeadingAge supports this intent and notes that SNFs are still required to make decisions related to level of care appropriately and in a timely manner and to monitor for changes in patients' conditions related to the continuing need for Part A SNF benefits after the assessment reference date of the initial assessment.

CONSOLIDATED BILLING

The consolidated billing provisions of Medicare Part A include several individual high-cost, low-probability services that are excluded from SNF consolidated billing within several broader categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) that otherwise remained subject to the provision. **We suggest CMS conduct a broad review of new chemotherapy drugs and their costs to determine if they should be added to the exclusion list,** as new drugs are being added regularly and do not always have their own HCPCS code.

REVISED GROUP THERAPY DEFINITION

LeadingAge supports revising the group therapy definition. As noted in the proposed rule, the social learning that occurs during group therapy is a benefit to both a resident's progress and quality of life; however, the restriction of the existing definition to exactly 4 patients creates barriers to therapists providing this service. Expanding the definition to include 2 to 6 patients will give therapists the flexibility to more readily utilize this valuable treatment option.

Additionally, adopting consistent definitions across post-acute care settings will help to streamline operations. LeadingAge supports the proposal to define group therapy as “a qualified rehabilitation therapist or therapy assistant treating 2 to 6 patients at the same time who are performing the same or similar activities”.

UPDATING ICD-10 CODE MAPPINGS

LeadingAge supports the proposal of a subregulatory process for making non-substantive changes to the ICD-10 code mappings and lists, SNF GROUPER software, and other such products used under PDPM. As stated in the proposed rule, ICD-10 medical code data sets are currently updated in June of each year by the ICD-10 Coordination and Maintenance Committee and code updates become effective in October 1 or April 1 of that year. The proposed rule does not clearly state whether non-substantive changes will be made according to this schedule.

A predictable schedule for updates is necessary given the importance of ICD-10 codes and related products in PDPM. Continuously checking the PDPM website to ensure accurate coding would substantially increase providers’ administrative burden, an outcome that conflicts with one of the intents of PDPM. **LeadingAge requests further clarification in the final rule on when providers can expect non-substantive changes to be made according to the subregulatory process.**

REVISIONS TO THE REGULATION TEXT

LeadingAge supports revising regulatory text to reflect changes effectuated by the implementation of PDPM such as conforming language related to assessments and the clarification of the 8-day assessment window. We request clarification, however, on the aspect of the interim payment assessment (IPA). CMS has been universally clear that the IPA is an optional assessment completed if the SNF determines necessary. This proposed rule states “the SNF’s responsibility in this context would include recognizing those situations that warrant a decision to complete an IPA in order to account appropriately for a change in patient status.” This seems to indicate that a SNF could be held accountable if an IPA is not completed on a patient who is determined to have experienced a change in status. **LeadingAge requests guidance on any exceptions or contingencies to the optional nature of the IPA.**

SNF Quality Reporting Program (QRP)

PROPOSED UPDATE TO THE DISCHARGE TO COMMUNITY – PAC SNF QRP MEASURE

LeadingAge supports updating the specifications for the Discharge to Community – PAC SNF QRP measure to exclude baseline nursing facility residents from the measure. SNFs provide quality care to diverse populations with varied goals and LeadingAge believes that patients should be supported to actively participate in their care planning. For some patients, this goal might be discharge to the community while for others, the goal is to attain or maintain their highest practicable physical, mental, and psychosocial well-being in the nursing home. To include both categories of residents in a measure that clearly only applies to the goals of one group is misleading and we support CMS’s proposal to provide an accurate measure of the quality care provided by SNFs by excluding baseline nursing facility residents from the measure.

SNF QUALITY MEASURES, MEASURE CONCEPTS, AND STANDARDIZED PATIENT ASSESSMENT DATA ELEMENTS UNDER CONSIDERATION FOR FUTURE YEARS: REQUEST FOR INFORMATION

While noted that CMS will not respond to comments submitted in response to this request for information in the FY 2020 SNF PPS final rule, we appreciate the opportunity to provide feedback on these proposed measures. Little detail is provided on the intent for these measures or the process for selecting these measures. LeadingAge suggests that the claims-based measure Healthcare-Associated Infections in Skilled Nursing Facility may benefit from subcategorization. It is not uncommon for a patient to be admitted to a SNF with either a hospital-acquired or community-acquired infection. The mere presence of a healthcare-associated infection is not an indicator of the quality of care provided by the SNF and therefore, the measure would not be serving its intended purpose of measuring quality of SNF care if no distinction is made in infection acquisition. **LeadingAge recommends that the Healthcare-Associated Infections in SNF measure be further revised to distinguish between SNF-acquired infections and non-SNF-acquired infections.**

PROPOSED STANDARDIZED PATIENT ASSESSMENT DATA BEGINNING WITH THE FY 2022 SNF QRP

Cognitive Function and Mental Status Data: We appreciate the extensive testing undertaken to ensure that selected standardized patient assessment data elements are reliable, valid and appropriate for intended use. Likewise, we appreciate CMS's intent to reduce assessor and patient burden by adopting the skip pattern embedded in the PHQ-2 to 9 that would allow an assessor to consider the mood assessment completed if a patient denies being bothered over the last 2 weeks by either of the first two items, "little interest or pleasure in doing things" and "feeling down, depressed or hopeless". We note that the two studies cited in the proposed rule^{1,2} validate the PHQ-2 for identifying depression, assessing depression severity, and monitoring mood over time; however, we are concerned that it may not be the most appropriate assessment for the population served in our SNFs.

Both of the cited studies included samples of noninstitutionalized older adults living in the community and while both studies concluded that the PHQ-2 was a valid screening tool for detecting depression in older adults, an alternative study³ found that the PHQ-2 was more accurate for younger adults while another study⁴ determined that the PHQ-9 was more accurate than the PHQ-2 for individuals with cognitive impairment. Additionally, in 2013 the fifth revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) updated diagnostic criteria for depression in older adults, recognizing that older adults are more likely to experience depression absent of the subjective experience of sadness.

¹ Li, C., Friedman, B., Conwell, Y., & Fiscella, K. (2007). Validity of the Patient Health Questionnaire 2 (PHQ-2) in identifying major depression in older people. *J of the A Geriatrics Society*, 55(4): 596-602.

² Löwe, B., Kroenke, K., & Gräfe, K. (2005). Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *J of Psychosomatic Research*, 58(2): 163-171.

³ Phelan, E., Williams, B., Meeker, K., Bonn, K., Frederick, J., LoGerfo, J., & Snowden, M. (2010). A study of the diagnostic accuracy of the PHQ-9 in primary care elderly. *BMC Family Practice*, 11(63). Doi: 10.1186/1471-2296-11-63

⁴ Boyle, L., Richardson, T., He, H., Xia, Y., Tu, X., Boustani, M., & Conwell, Y. (2011). How do the PHQ-2, the PHQ-9 perform in aging services clients with cognitive impairment? *Int J Geriat Psychiatry*, 26: 952-960. Doi: 10.1002/gps.2632

We cannot afford to miss depression in older adults simply because they do not subjectively identify themselves as feeling “down, depressed or hopeless” or having “little interest or pleasure in doing things.” Analyzing existing MDS 3.0 data to ensure that the PHQ- 2 to 9 would reliably capture SNF patients’ mood status will ensure accurate quality reporting, care planning, treatment, and reimbursement and **LeadingAge requests that this additional research be conducted prior to implementing the PHQ-2 to 9 skip pattern.**

Pain Interference (Pain Effect on Sleep, Pain Interference with Therapy Activities, and Pain Interference with Day-to-Day Activities): LeadingAge supports the addition of the Pain Interference data elements. While the opioid crisis has had a devastating impact on our country and we recognize that older adults are not immune to opioid addiction, pain is a valid issue and pain management is essential to quality of life. The goal of optimal functioning to attain and maintain the highest practicable quality of life is embedded in the policies of the skilled nursing field and we commend CMS for recognizing that pain management is a vital part of achieving that optimal functioning. We further support CMS’s attention to the risk of misuse or overuse of opioids in pain management through the addition of the standardized patient assessment data element (SPADE) addressing high risk drug classes. However, we are concerned by the statement “the standardized assessment of both opioids and pain interference would support providers in successfully tapering patients/residents who arrive in the PAC setting with long-term opioid use off of opioids onto non-pharmacologic treatments and non-opioid medications”. SNF providers are experts at skilled nursing care, not addictions treatment, and even an implicit expectation that a provider would engage in treatment beyond their scope of practice is not only unethical, but it puts the patient and provider at risk. While we support the application of best practices including non-opioid and non-pharmacologic interventions in pain management, **we suggest that the above statement and any related expectations be eliminated from the final rule and policy.**

Impairment Data – Hearing and Vision: We seek clarification around the expectations related to the impairment data SPADEs including hearing and vision. LeadingAge agrees that accurate diagnosis and management of hearing and vision impairment would likely improve patient safety, rehabilitation outcomes, and care transitions, but we are concerned by the statement, “Accurate assessment of hearing and vision impairment would be expected to lead to appropriate treatment, accommodations, including the provision of auxiliary aids and services during the stay, and ensure that patients and residents continue to have their vision and hearing needs met when they leave the facility.”

While it seems reasonable to expect a SNF to screen for impairment and provide some accommodations, resources, and referrals for treatment after discharge, a SNF should not be expected to undertake the burden and cost of pursuing treatment for these impairments for a short-stay SNF patient. If a patient is admitted for skilled care following a hip replacement surgery, the SNF should not be expected to send the patient out to an audiologist for hearing tests and hearing aid fittings and calibration, or to an ophthalmologist and optometrist for eye exams and eye glasses fittings, incurring costs related to transportation, companion or nurse aid services, or certain prescribed treatments or devices, and detracting from the time that the patient could be spending working toward treatment goals. **We suggest a provision is added to the**

final rule to clarify that a SNF is not responsible for pursuing treatments and services beyond the scope of care and services normally provided by the SNF.

Social Determinants of Health (SDOH) – Transportation, Social Isolation: LeadingAge supports the addition of SDOH to the SPADEs, recognizing how these elements impact care use, cost and outcomes for Medicare beneficiaries. **We believe that an accurate understanding of the impact of SDOH is imperative and suggest adding clarifiers to the SDOH measures for transportation and social isolation.** Adding a qualifying statement such as “in your normal home environment” to each of the two data elements would help patients to consider their normal daily living experiences rather than their acute experiences of the hospital and post-acute care stays when answering these questions. Additionally, while a SNF may provide a patient with resources and referrals to address the transportation issue post-discharge, a SNF should not be responsible for resolving patient transportation needs.

SNF Value-Based Purchasing (VBP) Program

SNFPPR Update – Change of Measure Name

Quality measures and data are only as good as their interpretation and we support CMS’s proposal to make the SNF VBP potentially preventable readmission measure more easily distinguished from the SNF QRP potentially preventable readmission measure by changing the name to Skilled Nursing Facility Potentially Preventable Readmissions after Hospital Discharge. **LeadingAge recognizes that this measure has not yet been adopted under its current name and asks for further guidance on when to expect the SNF VBP measure for potentially preventable readmissions.**

Public Reporting on SNF Performance Scores, Achievement and Improvement Scores, and Ranking

LeadingAge supports the proposal to suppress SNF information displayed on the Nursing Home Compare website in cases where SNFs have fewer than 25 eligible stays during baseline or performance periods. We agree that this will help ensure that information provided on a SNF’s performance under the program is meaningful and further suggest that **an explanation of this score suppression be clearly displayed on the Nursing Home Compare website to assist consumers in accurately interpreting the data available.**

Again, LeadingAge appreciates the opportunity to submit comments on the proposed rule. We value our collaborative relationship and look forward to working together toward improved quality of nursing home care. Please do not hesitate to contact us if you wish to discuss any of these comments further.

Sincerely,



Jodi Eyigor
Director, Nursing Home Quality & Policy