



August 12, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-6082-NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Verma:

Thank you for the opportunity to contribute to the Patients Over Paperwork initiative. The mission of [LeadingAge](#) is to be the trusted voice for aging. Our 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 50 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy, and applied research. We are invested in reducing administrative burden to allow our members to provide the highest quality care to the older adults in their communities and we value the collaboration between our 2 entities.

On June 6, the Centers for Medicare & Medicaid Services (CMS) released a new request for information related to its Patients Over Paperwork initiative. Having seen the incorporation of many of our suggestions from the initial request in 2017, we are pleased to have the opportunity to once again contribute to improvement of our healthcare system.

As we evaluated the feedback we receive from members, we identified a theme: our members are passionate about work that has meaning. Caring for older adults has meaning, but too often our members must take time away from older adults for administrative activities that have no meaning. Below, we provide examples of where meaning has been lost and suggestions for how to improve these processes.

Documentation Requirements

The importance of documentation is not lost on the professionals in our field. Documentation in the medical record communicates the details of an individual's care, provides a snapshot in time of the individual's status and functioning, and creates a sort of road map for where care has been and where it is headed. Documentation loses its meaning, however, when it becomes a process of checking boxes.

Consider the example of the Pre-Admission Screening and Resident Review (PASRR) form. This federally-required form, first created through the Omnibus Budget Reconciliation Act (OBRA) of 1987 to ensure that individuals with mental illness or developmental disability are not inappropriately "warehoused" in nursing homes, must be completed prior to the admission of an individual to a nursing home. It is most often completed by an attending physician or a social

worker in either a discharging hospital or a receiving skilled nursing facility. It documents the presence of a mental illness or developmental disability and prompts referral to the appropriate local agency. This form is a federally-required, unnecessary administrative burden.

As one social worker in a nursing home stated:

We spend hours on the PASRR. We're calling the hospital because the referral packet didn't include a PASRR, or it was filled out incorrectly. We're resubmitting PASRRs to the Medicaid office because the date of birth was omitted from the last page, even though it was included on the previous 4 pages. We're checking the PASRR every time a resident is admitted or readmitted after hospitalization. We're always checking for consistency with physician's notes, psychiatrist's notes, medication lists, care plans, and the MDS [Minimum Data Set 3.0]. Then, we're checking the PASRR every 9-15 months in preparation for our annual health inspection survey. And in the end, what is the point? The diagnoses, the symptoms, and any behaviors are already recorded in clinical notes, assessments, and the care plan. If the resident shows impaired functioning because of mental illness or developmental disability, we make the referral, not because the PASRR told us to, but because it benefits the resident and the nursing home to have that additional support.

For another example of excessive documentation, we look to Medicare Advantage (MA) plans. When a beneficiary receives home health services, MA plans require authorization for each service, for each discipline. Each authorization requires medical record documentation including the Outcome and Assessment Information Set (OASIS), plan of care, and clinical notes, at a minimum. This information is even required for authorizations of ongoing services that meet Interqual and Milliman criteria for medical necessity. Collecting and submitting documentation for each individual service requires extraordinary and unnecessary administrative burden.

Additionally, these requirements pose barriers to older adults seeking to receive the support necessary to remain in the places they call home. MA plans refuse payment for services provided by a home health agency prior to authorization, yet these authorizations are not timely. The home health agency is responsible for the care of the individual and is now faced with the difficult choice of providing services that the individual cannot afford and for which there will be no MA reimbursement, or to forego services until the necessary authorizations are received.

Lastly, we ask CMS to examine the larger picture of the role of documentation. When a resident falls in a nursing home, the priority should always be providing the immediate and, as necessary, emergent care that the individual requires. When we cite a nursing home for not completing paperwork within arbitrary time limits because staff were busy providing care to the resident, where have we placed priority? Certainly not on quality of care.

We encourage CMS to reexamine the role of documentation, including the use of the PASRR and home health authorization procedures, for opportunities to eliminate duplicative and excessive documentation requirements. Provide meaning in documentation requirements that efficiently tell the story of care.

Quality Measures and Reporting

We are fortunate to live in a society where consumers have a choice in the products they purchase. In order to make good choices, consumers must have information that is complete,

factual, and objective. In healthcare, this information could be communicated through quality measures, but our quality measures have lost meaning.

Consider the example of the long-stay antipsychotic medication measure currently in use for nursing homes. This measure indicates that a nursing home is providing poor care if a Medicare beneficiary receives an antipsychotic medication without a diagnosis of schizophrenia, Tourette's Syndrome, or Huntington's Disease. Antipsychotic medications pose a number of risks to older adults due to age-related changes, comorbidities, and the effects of polypharmacy. Antipsychotics have additionally been used in some cases to manage dementia-related behaviors that could better be treated through non-pharmacologic interventions. Given this information, one wonders what story of care the antipsychotic measure seeks to tell. If the goal is to address the inappropriate use of antipsychotic medications in individuals with dementia, why does the measure not include criteria for a dementia diagnosis? If the goal is to address the use of antipsychotics in older adults, why is this measure only in use in nursing homes. Older adults receive services from hospitals and home health agencies, yet no antipsychotic quality measures have been adopted for either of these provider types.

Additionally, the very number of quality measures renders them meaningless. Hospitals and nursing homes contend with around 30 quality measures each, while home health providers report on over 40 quality measures. Overwhelmed by this information that rarely overlaps, consumers are unable to determine what factors are the most important indicators of quality care, and providers are stretched to identify which areas are most important for quality improvement efforts.

We urge CMS to continue work to adopt quality measures according to the principles identified in the Meaningful Measures initiative. Adopt measures that are patient-centered and meaningful to patients, clinicians, and providers in the context of quality care and that will align across payment programs and provider types.

Interoperability

A significant frustration for providers across the continuum of care is the need for interoperable health information systems. Many providers have switched to electronic health records over the years and multiple methods of health information exchange have been initiated by hospitals, healthcare provider networks, insurance companies, and even local government agencies, but these systems are still highly ineffective. A beneficiary may be included in multiple separate systems that are inaccessible to outside providers. Systems are challenging to navigate and disempower the beneficiary from being a leader in his own care. These fractured systems impair clinicians' abilities to provide optimum care when they are unable to access a holistic view of the beneficiary and his health, or to collaborate effectively with other providers involved in the individual's care.

For example, face-to-face documentation is required to authorize most home health services. Some Medicare Advantage plans require that face-to-face documentation related to a claim be filed within 90 days of the visit. It is sometimes incredibly difficult to obtain the required documentation from physicians and requires enormous resources on the part of the provider to follow up, often multiple times, in order to obtain the required documentation. Were the health system and records interoperable, the burden of obtaining this documentation would

significantly decrease. It may even empower Medicare and Medicare Advantage plans to adopt new, more efficient methods of verifying and authorizing payment for necessary services.

CMS has been working to address this issue through the MyHealthEData initiative. A new pilot program was announced on July 30 that would give clinicians access to claims data to fill in gaps in health information. We support these efforts and encourage CMS to include aging services providers in national health information technology initiatives, including the development, adoption, and use of interoperability standards, certification of information technology products, and electronic health record incentive programs. We further advocate for inclusion in health information exchange activities and technical assistance programs, particularly those designed to assist in the adoption of electronic health records and interoperability in rural settings. Create a system that allows providers and beneficiaries to communicate meaningfully with one another to improve care.

Provider Participation Requirements

Across provider types, a common concern is the inconsistency in the survey process. Standards for compliance are put forth by CMS, but the interpretation of these standards can vary so drastically among surveying agencies that the process has lost its intended meaning.

Data from 2018-2019 nursing home surveys show that the average number of deficiencies by state ranged from fewer than 3 deficiencies per survey to more than 14. While care may vary between homes, it does not vary this significantly between states. State survey agencies differ in their approaches to the survey process, priorities for inspection, and even interpretation of the regulatory requirements. This places a significant burden on providers who, rather than exploring areas for quality improvement and working toward consistent standards of care, spend time chasing behind survey results, completing plans of correction based on arbitrary findings and putting processes in place to avoid future citations on an issue that may have relatively little impact on the overall quality of care.

CMS has acknowledged that inconsistencies exist and are working to make improvements. We appreciate this process and encourage CMS to continue efforts to improve consistency in the survey and certification process. We recognize that this will likely create higher incidence of survey citations. We are working to prepare members for this possibility and offer suggestions that CMS could put in place to off-set this possibility.

Joint education of surveyors and providers would ensure that both parties have the same understanding of the regulations, especially when new regulations are adopted. This will be particularly relevant to phase 3 of the Requirements of Participation and the implementation of the Patient-Driven Payment Model. Mirror requirements of the nursing homes they survey by identifying and requiring surveyors to demonstrate competency in a set of standard knowledge, skills, and abilities that are critical for surveyors and survey team leaders. Establish a standard for credentialing surveyors and require ongoing education, evaluation, and recertification. Reestablish meaning in the survey and certification process by making it a valid and reliable measure of quality of care.

Audits and Claims

Another issue pervasively affecting providers and patients is the issue of observation stays in hospitals and the subsequent denial of skilled care under Medicare Part A. Recognizing that

CMS is unable to change the 3-day qualifying stay requirement, we note that CMS is able to enact changes that would consider all time spent in the hospital, regardless of admission status, as applicable toward the 3-day qualifying stay. CMS has acknowledged that care received under observation status can be indistinguishable from care received as an inpatient. When older adults leave hospitals, they are often in need of post-acute care to help them regain a level of functioning that an acute medical event and subsequent time spent immobile in a hospital bed has caused them to lose. We urge CMS to alleviate burden on patients, hospitals, and post-acute care providers by eliminating the inpatient status distinction from the required 3-day qualifying stay.

Additionally, when discussing burdens related to claims, we turn to Medicare Advantage plans. Providers report significant issues with timely, accurate payment from these plans. Claims are denied erroneously, or payment is retroactively recouped for a prior-authorized service. This problem is exacerbated when the MA plan contracts out to a third party utilization management company. These companies often have their own sets of rules that are even more aggressive and burdensome than the MA plans's requirements and result in greater rates of onerous documentation requests and erroneous denials. We urge CMS to adopt meaningful claims policies that provides timely, accurate payment for services that help older adults maintain a quality of life.

While the examples provided above refer specifically to nursing homes or home health, we feel that the general topics can be applied across provider types. Burden from unnecessary and duplicative assessments, empty quality measures, inadequate health information exchange, inconsistent survey and certification processes, and problematic audit and claims processes are echoed across our membership. We encourage CMS to use these examples as a jumping-off point to examine opportunities to reinstate meaning by streamlining administrative procedures across the aging services spectrum of care.

We appreciate the opportunity to contribute once again to this project and welcome any questions or solicitations for further feedback.

Sincerely,

A handwritten signature in cursive script that reads "Jodi Eyigor".

Jodi Eyigor
Director, Nursing Home Quality & Policy