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

June 25, 2018

Ms. Seema Verma, MPH
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 Proposed Rule, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities FY 2019, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research; Proposed Rule. Federal Register, Vol. 83, No. 89, Tuesday, May 8, 2018. CMS-1696-P (RIN 0938-AT24)

Dear Administrator Verma:

The American Health Care Association 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. In this letter, AHCA comments on a SNF Wage Index, Consolidated Billing exclusions list, a robust critique of PDPM including constructive solutions, the SNF Quality Reporting Program, the SNF Value-Based Purchasing Program, and a response to the Interoperability RFI.

In the remainder of this cover letter we focus on PDPM, proposed as the most significant SNF payment policy change in decades. As CMS advances PDPM, the Association urges CMS to recognize the financial plight of the SNF profession. Members are struggling with eroding rates in Medicare and Medicaid producing the lowest operating margins since the late 1990s (see ***Table 1***, below).

Table 1. Comparison of Median SNF Medicare Part A Fee-For-Service Margin, Non-Medicare Margin, and Total Margin, 2013-2018

Federal Fiscal Year	SNF Medicare Margin	Non-Medicare Margin	Total Margin
2013	13.1%	-1.9%	1.9%
2014	12.5%	-1.5%	1.9%
2015	12.6%	-2.0%	1.6%
2016	11.4%	-1.5%	1.9%
2017	10.6%	-2.0%	1.6%
2018 (Projected)	9%	-2.3%	0.7%

Source: MedPAC Data Summarized by the American Health Care Association

We understand the challenges CMS is attempting to solve with PDPM. However, we believe PDPM could create new challenges without additional simulation and notable refinements. Regarding our concerns, we believe PDPM still would not mitigate access barriers for patients with high non-therapy ancillary service costs. Additionally, as we have shared with CMS and CMS' contractor, Acumen, we do not believe the data and related analytics are sufficient to support the model. We believe further simulation is needed, study on the components, and a thorough retooling of the assessment proposals, particularly the proposed new use of multiple ICD-10 codes on the MDS, and the interrupted stay proposal. Furthermore, reductions in payment to Medicare low-volume providers would perpetuate, if not exacerbate, existing access issues.

AHCA has invested considerable resources studying PDPM and the underlying analytics. We also continue to believe that the omission of alignment with critical policy initiatives in the proposed payment framework, such as the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act), the Protecting Access to Medicare Act of 2014 SNF Re-hospitalization Value-Based Purchasing Program (SNF-VBP), and the Requirements for Participation (RfP), is very troubling. During the technical expert panels, Acumen repeatedly indicated that other SNF-related laws for which CMS is responsible, as well as other SNF 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. In the sections below, we request responses and explanations for how these SNF requirements were, or will be, accounted for in PDPM design.

In recent months, CMS has launched a significant effort titled "Patients Over Paperwork" in response to President Trump's Executive Order that agencies develop initiatives to reduce or eliminate red tape. PDPM and its proposed ICD-10 detailed documentation requirements do not support CMS' Patients Over Paperwork *Simplifying Documentation Requirements*.

We believe an integrated approach (i.e., quality, regulatory, and payment impacts) is required to hold true with CMS' Patients over Paperwork initiative as well to address new PDPM burden. Under PDPM, new payment implications and additional items associated with MDS coding increase the focus on generating even more medical documentation to support the codes used. Such additions could create new challenges associated with securing supporting documentation to ensure timely payment. For example, CMS proposes to require the use of multiple ICD-10 diagnosis codes and, potentially, ICD-10 procedure codes, on the Minimum Data Set (MDS) patient assessment. We see this as the most challenging proposed PDPM feature that requires revision. SNFs have very little experience with using fully-specified ICD-10 coding– diagnosis or procedure beyond current limited claims processing requirements. And, the addition of new and extensive MDS ICD-10 coding requirements create a new layer of complexity in day-to-day operations, which will increase the probability of provider error. AHCA has developed and is proposing an alternative MDS-based condition and comorbidity reporting approach option for resident classification purposes. We believe the concept supports CMS' goal of

focusing care on patient conditions but avoids the significant burden additional MDS ICD-10 coding would create.

While we understand the NPRM is CMS' first attempt to formally solicit feedback on the PDPM PPS, we have deep concerns about advancing PDPM without an in-depth and ongoing collaborative discussion about transition plan development, a transition timeline (e.g., October 1, 2019, might or might not be feasible), implementation, and post-implementation problem solving. **Specifically, we believe CMS must form a standing stakeholder work group to engage with CMS transparent and meaningful manner on the topics, above. PDPM is complex and stakeholder input could aid CMS with its PDPM efforts as well as reduce unintended consequences for patients. We recommend mirroring the stakeholder engagement process CMS used for the transition from cost-based payment to the current RUG-based PPS.**

The Association offers these comments, while direct and assertive, collegially and in the spirit of collaboration. Our tone and the level of detail are intended to convey the Association's commitment to improving Medicare payment accuracy, beneficiary access and adequacy of payment to ensure high quality care. We also are committed to supporting CMS in its Patients Over Paperwork effort as well as its overarching Medicare payment policy priorities.

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
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 of CMS' request for comment on a SNF Wage Index, Consolidated Billing, Patient-Driven Payment Model (PDPM), the IMPACT Act QRP, the SNF VBP program, and the Interoperability Request for Information (RFI). In regard to PDPM, we are supportive of CMS' direction and appreciate the array of changes made to RCS-1 as it evolved into PDPM. However, we strongly believe a number of significant action steps are needed before PDPM is implemented. The Association stands ready to collaborate with CMS on such efforts.

Below we offer high-level statements which summarize our comments as well as page-by-page references to specific detailed comments related to the high-level statements. In regard to our PDPM comments, we have prioritized our comments in order of importance (see ***Table 1***, below).

- ***Section 1 – SNF Wage Index.*** AHCA proposes both an interim step towards a SNF wage index as well as a phased longer-term plan. In the short term, the Association proposes "trimming" hospital data to eliminate labor categories which are not found in SNFs as well as to account for the differences between hospital employee and SNF employee benefit costs. In the longer term, AHCA has recommended a phased approach of gradually shifting away from the current hospital based system to SNF wage data. We propose shifting from 25% hospital based wage data and 75% SNF wage data in year one with year-over-year increases in SNF wage data use by 25% per year. Once the transition begins, a four-year phase-in would begin with protections for increases or decreases of more than 5% until the transition is complete. See **page 9**.

- ***Section 2*** – ***Consolidated Billing***. The Association has long believed that CMS takes too narrow an interpretation of its flexibility in the four exclusion areas as well as in its interpretation of the definition of a "resident of skilled nursing facility" which has implications for site of service challenges. CMS policy has not kept pace with the entry of new, very high cost medications to the health care market, including over 100 drugs which fall within CMS' exclusion criteria. CMS should add at least these medications to its exclusion list immediately. Second, the definition of a "resident of a skilled nursing facility" has limited exclusion of high-cost services that now are often delivered in specialized imaging centers, ambulatory surgical centers, and other outpatient settings. CMS should modernize its policies and avail itself of the flexibility available in the definition noted above. See **page 14**.

- ***Section 3 – Patient-Driven Payment Mode (PDPM).*** For a number of years, AHCA has participated in an array of SNF payment reform technical expert panels and submitted extensive comments on CMS' SNF payment reform work. The Association appreciates many changes made to the 2017 Resident Classification System Version 1 (RCS-1) concept. The PDPM concept is simpler than RCS-1 and CMS incorporated a number of AHCA requests for clarification and modifications. We go into great detail in Section 3. For purposes of the Executive Summary, we offer our top priorities for PDPM changes before the payment system is finalized. See Table 1, below, for our PDPM top issues. In addition to the points below, we urge CMS to return to the RCS-1 group and concurrent therapy proposal of 25% for group and 25% for concurrent rather than the PDPM proposal. See **page 25** to view our detailed PDPM section.

- ***Section 4 – SNF Quality Reporting Program (QRP).*** AHCA is a strong supporter of the SNF QRP initiative and offers support for several of the proposed future improvements to the SNF QRP program. We also offer comments related to concerns with the content and timing of public display of the MSPB and mobility and self-care outcomes measures. See **page 131**.

- ***Section 5 – SNF Value-Based Purchasing Program (VBP).*** AHCA appreciates the careful consideration CMS has put towards ensuring the SNF VBP program is administered fairly for all centers, even those with special considerations such as small SNFRM denominator sizes, newly opened facilities without baseline SNFRM data, those with a high proportion of patients with social risk factor and those affected by extraordinary circumstances outside of their control. We believe that the proposed additions to the program made in the NPRM will ensure that no centers are unfairly harmed by the VBP scoring methodology. See **page 136**.

- ***Section 6 – Interoperability Request for Information.*** AHCA appreciates the value and importance of interoperable health information data elements. However, the SNF profession is struggling financially and does not receive financial assistance for information technology under the HITECH Act or from other sources. In Section 6, we offer creative financing options for CMS consideration, suggestions for a LTPAC IT Technical Expert Panel, and will reach out to the Office of the National Coordinator to share our ideas. See **page 140** for more detail.

Table 1 – AHCA Top Comments on PDPM

Broad Challenge	Specific PDPM Concerns	Recommended Solution &/or Request for Clarification
PDPM Remains Complex – More Can be Done to Reduce Provider Burden	The ***Interim Payment Assessment (IPA)*** proposal is unnecessarily complicated and would require more staff attention to process rather than delivering patient care	• IPA as proposed creates new SNF burden • CMS should clarify what patient characteristic changes trigger an IPA • Thresholds should be set in IPA policy for NTAS to be reset to Day 1 in certain scenarios

	The proposed Use of multiple ***ICD-10-CM or PCS Codes*** on MDS for resident classification is not required by HIPAA as part of a "transaction" and would be a significant challenge for SNFs and would offset any perceived burden relief benefit from the proposed elimination of the current MDS and Other Medicare Required Assessments (OMRA)	• Fully-specified ICD-10 coding is not essential nor required on the admission MDS for resident classification and AHCA offers an alternative approach and this burden could offset any potential burden relief from fewer SNF PPS assessments for longer-stay residents
		• The PDPM proposal does not reduce or acknowledge the ongoing burden associated with other mandated assessments including:
		  ○ SNFs still will be required to update clinical assessments in order to maintain an up-to-date Comprehensive Person-Centered Plan of Care
		  ○ OBRA required assessments continue during the SNF stay

	Reporting ***therapy minutes*** on the discharge MDS and claims is redundant	• AHCA strongly opposes the reporting of therapy services in Section O of the SNF PPS Discharge MDS under PDPM as proposed • AHCA recommends an alternative solution where the reporting of similar information of therapy services on claims better serves to achieve the CMS intent while limiting provider burden • AHCA recommends that in evaluating the impact of PDPM implementation on therapy service delivery patterns, CMS must do so in the context of the impact on CMS-developed quality and outcomes measures that are commonly associated with effective rehabilitation services

	Non-Therapy Ancillary Services (NTAS) component carries the current disincentives to admitting high cost, medically complex patients into PDPM, or to discharge to hospital if NTA needs change unexpectedly and dramatically	• AHCA offers two solutions to address interaction of the NTAS component tapering with assessment proposals:
		  ○ Initial/Admission Assessment – Build on the Existing RAI Modification Provision and Lengthen 5-Day Assessment/Correction Window
		  ○ Develop an IPA Threshold for NTAS Reset to Day One
		• Clarification is needed on
		  ○ Changes to the Conditions and Extensive Services list in PDPM relative to the RCS-1 list; and

Table 1 – AHCA Top Comments on PDPM

Broad Challenge	Specific PDPM Concerns	Recommended Solution &/or Request for Clarification
System Stability and Beneficiary Access is a Concern – CMS Appears to have Created New Beneficiary Challenges		○ Explanation of how high-cost conditions and extensive services will be paid for that are not on the list. AHCA suggests the creating of a default category and related rate development concept.
	The ***Interrupted Stay Policy and the inability to reset NTAS*** creates a payment system incentive which runs counter to other SNF programs and policies and could create beneficiary issues	• AHCA supports an interrupted stay policy but with modification ○ The number of days (</= 3; >3) should not matter, rather the patient condition. SNFs are required to re-assess at admission for care plan development. ○ The same parameters as under our IPA proposals could be used ○ Could save program dollars if readmitted without triggering day 1 clinical tapering reset • SNFs are subject to a SNF Value-Based Purchasing Program as well as IMPACT Act Quality Reporting Program Measures. CMS should utilize those tools in operationalizing the interrupted stay policy and related monitoring rather than "additional scrutiny"
	CMS has proposed PDPM as ***budget neutral***; however, AHCA analysis indicates a number of concerns with leakage from the payment system, which could result in underfunding or overpayment, which could result in unanticipated expenditure growth.	• Short-term and Long-term recalibration strategies are needed ○ "Budget Neutrality Recalibration" – should be done if needed during implementation year by changing the budget-neutrality factor ○ "Model Design Recalibration" – should done in subsequent rulemaking using "real life" data to address errors in design assumptions • Leakage Challenges ▪ Hospital MS-DRG information to set rates likely will result in lower payments than predicted ▪ SNF Charge to Estimated Cost likely will result in under payment for high cost cases ▪ Lack of Component Wage Adjustment May Lead to Dropped Services • Potential Overages ▪ Section GG reverses the Section G scoring structure and likely will result in completion challenge and inadvertent errors ▪ Many MDS elements traditionally used only for care planning, including depression, would impact PDPM payment, and

Table 1 – AHCA Top Comments on PDPM

Broad Challenge	Specific PDPM Concerns	Recommended Solution &/or Request for Clarification
		changes in usage (appropriate or not) may require monitoring for appropriate recalibration. • CMS should engage in an ongoing SNF Stakeholder Work Group as it did in the transition from cost-based payment to the RUG-based PPS to address these concerns as well as AHCA's other comments, suggestions, and requests for clarification. Already AHCA has been working with a group of 14 organizations on SNF Payment Reform, which could serve as the basis for such a work group.

Section 1 – Skilled Nursing Facility Wage Index

CMS Request for Comment	AHCA Comment Highlights
Page 21032 -- Given the perennial nature of these comments and responses on the SNF PPS wage index policy, we are requesting further comments on the issues discussed above. Specifically, we request comment on how a SNF-specific wage index may be developed without creating significant administrative burdens for providers, CMS, or its contractors. Further, we request comments on specific alternatives we may consider in future rulemaking, which could be implemented in advance of, or in lieu of, a SNF-specific wage index.	• AHCA offers an interim step for a more appropriate hospital-based SNF wage index using trimmed hospital data • AHCA also offered a phased approach to implementing a SNF wage index with protections for SNFs as adjustments are made across CBSAs within the budget neutral envelope • For both the interim step and a movement to a SNF-Specific Wage Index we offer recommendations for education and technical support

General Position Statement

AHCA has long supported a SNF wage index but only with protections for SNFs during the transition as the new approach to a wage index impacts (e.g., some SNFs will experience decreases while others will experience increases).

Background

AHCA appreciated CMS' request for input on a SNF-specific wage index which the Agency has the authority to develop at Section 315 of the Medicare Provisions in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554).

To aid CMS with its goal of enhancing payment adequacy and accuracy, AHCA has developed an interim step towards a SNF wage index that the Association believes meets the criteria the Agency describes on page 21032 of the NPRM. AHCA has presented this approach to CMS twice and believes the Agency should have had adequate time to evaluate the proposal and implement the interim step in FY 2019.

1. SNF Wage Index Today

Since 1997, CMS had 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 Departments, ambulatory surgical centers, home health agencies, and hospice facilities.

The wage index used for the SNF PPS is calculated using the Inpatient Prospective Payment System (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 methodology does not appropriately, nor adequately, adjust Medicare payments for differences in wage rates across geographic regions for post-acute care providers nor does it account for occupational mix differences between hospitals and PAC providers.

The deficiencies in the wage index methodology for adjusting Medicare payments have been known for many years and has been analyzed and critiqued by several leading analytic/research institutions: among them, the Medicare Payment Advisory Commission (MedPAC), Acumen LLC, RTI International, and the Institute of Medicine (IOM). ***Current Wage Index Challenges*** Since the inception of the Medicare Skilled Nursing Facility (SNF) Prospective Payment System (PPS) in 1998, the area wage index calculated for the hospital PPS has also 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.

Depending on the SNF's assigned CBSA, the area wage index is multiplied by 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% of the total RUG rate, the wage index has a significant impact on the final RUG rates for each CBSA. As a result, any statistical error, distortion, or bias caused by either providers submitting inaccurate data or the use of a proxy that does not appropriately reflect the true SNF labor market may have significant financial consequences for all providers in any given CBSA. An area wage index less than a 1.0000 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 and vice versa for CBSAs with an area wage index of greater than 1.0000.

AHCA has long believed a skilled nursing facility (SNF) specific wage index is far more appropriate than using hospital wage data as a proxy. And, over the years, the Association has repeatedly highlighted this concern. In turn, the Centers for Medicare and Medicaid Services (CMS) has indicated SNF data has been unreliable for the purpose of developing a SNF-specific wage index. As discussed in our FY17 comments, AHCA has developed an approach we believe aligns with CMS' current approach to using audited, hospital wage data to avoid additional

[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.

burden on CMS staff and contractors. Specifically, we suggest filtering hospital wage data so it is more appropriate for developing the SNF wage index and applying a SNF-specific occupational mix adjustment to the filtered hospital data.

Additionally, the Association believes CMS must take steps to address instances where SNFs in counties with no or very few hospitals are disproportionally impacted by poor hospital data or by CMS or federal contractors' decisions about the inclusion or exclusion of hospital data. For FY 2016 alone (based on FY 2013 hospital labor data), the Association's analysis of hospital wage indices impacts shows that 157 CBSAs will experience more than a 5% decrease in the SNF wage indices if a BLS Occupational Mix Adjustment is applied. This number increases to 190 CBSAs if HCRIS (SNF Cost Report) data is used to apply an Occupational Mix Adjustment. Complicating matters are the consolidation of hospitals as well as hospital acquisition of physician practices and outpatient settings such as Ambulatory Surgical Centers (ASC).

Of the 157 CBSAs, 85 CBSAs had double-digit decreases. Eighty-five increases to 94 if HCRIS data is used to apply an Occupational Mix Adjustment. Our research on these counties revealed issues with hospital non-submission of data or serious issues with hospital data – most notably the employee benefit portion of the labor data. We also found that if the Rural Floor policy that currently applies to hospitals pursuant to their IPPS Rule had been applied to SNFs in 2016, there would have been 159 CBSAs eligible for a higher Wage Index and 38 of those would have been greater than 10%. CMS should develop a protocol to investigate significant year-over-year swings in hospital labor data-driven wage index changes. A reasonable benchmark for "significant" could be more than 10% (this would cause roughly a 7% change in a SNF's RUG rates assuming a 70% labor component). To that end, SNFs and AHCA state affiliates have been working with hospitals to ensure hospital data is as complete and accurate as possible. However, successful collaboration is highly dependent upon a hospital's willingness to coordinate.

2. Proposed Solutions

a. MLN Transmittal

The Agency should immediately develop a Medicare Learning Network (MLN) transmittal to hospitals articulating: 1) the importance of accurate wage data due to its role in setting post-acute care (PAC) provider wage indices; 2) a new process for reporting hospital data in a format suitable for PAC provider settings and that accounts for occupational mix differences between hospitals and each PAC setting (see below); and 3) CMS' expectations for hospitals to collaborate with PAC providers on accurate submissions as well as correcting incorrect submissions that impact PAC providers.

b. Interim Wage Index Step -- Modified Hospital Wage Index

Area wage indices are based on labor data reported on the hospital Medicare Cost Report, Worksheet S-3 Part II and III and via an annual Survey. While similar data is reported on the SNF Medicare Cost Report, CMS has long maintained 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, and is just as reliable as, 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 and other PAC PPS settings even more problematic and volatile.

Further, there are provisions within hospital regulations that allow for hospitals to reclassify to another area for purposes of the wage index, and that limits the application of wage indices to payment rates when they are below the rural index of the State. No such relief is afforded PAC providers until at least SNF labor data is used as the basis for a SNF Wage Index.

Given these inequities, AHCA urges CMS explore the development of an alternative wage index, while still using much of the wage data reported on the hospital Medicare Cost Report. Specifically, AHCA suggests that CMS develop a wage index based on staffing and labor data that are similar for both hospitals and PAC providers, while removing labor data that is specific to hospitals, only. The resulting index could be further tailored to PAC by weighting it by publicly available occupational mix data for each PAC provider sector that is published by the Bureau of Labor Statistics (BLS).

AHCA/NCAL undertook the following steps to modeling 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 and residents, and other teaching physician costs, and excluded other non-reimbursable cost centers not normally present in skilled nursing facilities. The related portion of fringe benefits and overhead were also removed.

2. Using the formula and processes established by CMS and delineated in the Federal Register, AHCA/NCAL 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. A similar basic step could be taken for each PAC provider type.

3. AHCA/NCAL 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. Again, this basic step could be completed for each PAC provider type.

Below we describe the specific steps to a hospital trimmed data approach:

- ***Step 1*** – 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 potion of the SNF RUGs' published rates beginning October 1 of each federal fiscal year.

- ***Step 2*** – The alternative method of calculating the unadjusted wage index excludes cost centers more predominate in IPPS hospitals versus SNFs, including non-reimbursable cost centers (freestanding clinics and physician practices), Part A and Part B physicians, Interns and Residents, and overhead cost centers Cafeteria, Central Supply and Services, and Pharmacy. As a result of the aforementioned exclusions, the IPPS unadjusted wage index method of calculating overhead. Additional exclusions comprise of core benefits as outlined at Step 3 and home office wages and hours, which differ in an IPPS hospital versus SNF setting. Patient care contracted labor reported on the IPPS hospital Medicare cost report is included in the alternative method.

- ***Step 3*** – Exclude the IPPS hospitals' core benefits in calculating the alternative method for the unadjusted wage index. The decision to exclude the IPPS hospitals' core benefits in calculating the alternative method for the unadjusted wage index was the result of 1) varying employee benefit factors for IPPS hospitals versus SNFs when examining Bureau of Labor Statistics (BLS) data; 2) CMS audited PU File Worksheet S-3, Part II data which reflects employee benefit percentages for Core Based Statistical Areas (CBSAs) ranging from 13.20% to 49.82% [Source: FY16 July 2015 published CMS PU File where S-3, Pt II data Lines 17-25 are divided by Line 1]; 3) FY14 SNF benefits by IPPS hospital CBSAs result in 75.47% of SNFs having a benefit range of between 15% and 25% whereby, IPPS hospitals by CBSA, using the July 2015 CMS PU File, result in 61.01% of IPPS hospitals having a benefit range of 26% and higher. This difference in employee benefit factors was causing a significant portion of the non-occupational mix variance between Wage Indexes established using the full hospital labor dataset and those that would have been set using SNF Labor data from the same cost reporting fiscal year.

- ***Step 4*** – Calculate overhead rate by first excluding Cafeteria, Central Supply and Services, and Pharmacy (Step 2) by 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. This results in alternative overhead salaries excluding Cafeteria, Central Services and Supply, and Pharmacy. Next, arrive at adjusted overall wages for which overhead

is to be divided by an overhead percentage by subtracting S-3, Pt II Lines 36, 39, and 40 from S-3, Pt II Line 1, Total Salaries. Using the alternative method, adjusted Worksheet S-3, Pt II. Total Overhead Cost Salaries on Line 7 divided by Worksheet S-3, Pt II Line 1 Total Salaries results in an overhead percentage to be applied to reimbursable salaries (see next steps).

- ***Step 5*** – Calculate reimbursable salaries excluding overhead (factor to be applied per Step 4) and Physician Part A Salaries. Using Worksheet S-3, Pt III, Line 3 Subtotal Salaries, subtract S-3, Pt II Lines 36, 39, and 40 (excluded overhead per Step 4). This results in allowable wages per the unadjusted IPPS hospital wage index, including applicable overhead and Physician Part A salaries. Next, subtract adjusted overhead calculated at Step 4 and Worksheet S-3, Pt II, Line 4 Physician Part A salaries. This results in the alternative allowable salaries less overhead and Physician Part A salaries.

- ***Step 6*** – Using the overhead factor calculated at Step 4, multiply this factor + 1.0 to calculated reimbursable salaries at Step 5. This results in the alternative adjusted salaries less contracted patient care amounts by each IPPS hospital in the CMS PU File.

- ***Step 7*** – Arrive at the contracted patient care amounts using Worksheet S-3, Pt II, Line 11.

- ***Step 8*** – Calculate reimbursable salaries and wages, unadjusted for benefits as described at Step 3, by adding the results of Step 6 and Step 7. This calculated amount by IPPS hospital represents the alternative salary and wage amount to be used for SNF wage index purposes prior to indexing for the midpoint (IPPS hospital wage index) and partial cost reporting periods contained in the CMS PU File.

- ***Step 9*** – Following Step 4 through Step 8 compute reimbursable hours.

- ***Step 10*** – The result of Step 8 divided by Step 9 is the unadjusted salary and wage rate by IPPS hospital provider.

- ***Step 11*** – 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 Step 4 through 10.

c. *Development of a Phased SNF-Specific Wage Index*

In order to recalibrate the Patient-Driven Payment Model (PDPM) accurately, CMS will need as much accurate SNF data as possible. We that believe the SNF cost report labor

data as reported on S-3 is valid and could be used to set a SNF-specific wage index. However, to draw specific attention to the importance of the labor data and as part of PDPM recalibration planning (see Section 3, Subsection J: Future PDPM Performance Considerations), AHCA recommends the following: a) develop more detailed instructions related to labor reporting sections of SNF Cost Report. The Association would be pleased to draft such detailed instructions for CMS consideration with specific focus on collecting easily auditable data for wage index and PDPM purposes; b) develop a series of Level 1 cost report edits (with "fatal errors") that apply to worksheet S-3 of the SNF cost reports; c) transmit a MLN describing the cost reporting protocols related to labor reporting and why they are necessary; and d) hold a SNF webinar emphasizing the cost reporting requirements.

We also believe any impact associated with audits of SNF Labor data could be applied prospectively to SNF rates even if the audits are conducted subsequent to the cost reported data being used to establish the wage indexes for any specific rate year. The results of provider audits could be applied as adjustments to the CBSA wage indexes for future prospective rate periods. Audits could be incorporated with the currently planned audit of PBJ labor data since the auditors are already requesting the payroll documents and contractor invoices they would need to validate the labor information for a SNF Wage Index.

During transition to a SNF-specific wage index, some SNFs will experience notable increases while others will experience decreases. Steps must be taken to mitigate these swings due to the statutorily budget neutral nature of the SNF payment system and the financial fragility of the SNF sector. AHCA recommends using a hospital alternative unadjusted wage index method/SNF blended wage index approach similar to the transition from the SNF cost-based payment system to the existing RUG-based PPS. CMS should spread the transition over four years using the following schedule – 25% SNF and 75% hospital, 50% SNF and 50% hospital, 75% SNF and 25% hospital, and, finally, 100% SNF. CMS also should include caps of upper and lower 5% caps (a stop-gain and stop-loss "corridor") for each transition year to prevent significant swings along with the blended approach.

Section 2: Consolidated Billing

CMS Request for Comment	AHCA Comments
Page 21033 – In this proposed rule, we specifically invite public comments identifying HCPCS codes in any of these four service categories (chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices) representing recent medical advances that might meet our criteria for exclusion from SNF consolidated billing. We may consider excluding a particular service if it meets our criteria for exclusion as specified above. Commenters should identify in their comments the specific HCPCS code that is associated with the service in question, as well as their rationale for requesting that the identified HCPCS code(s) be excluded.	• AHCA requests that CMS exclude from the Part A bundle high cost and low probability chemotherapy drugs that have been approved by the U.S. Department of Health and Human Services Food and Drug Administration (FDA) since 1999, as per the Agency's authority and related Congressional intent explanations; • CMS should examine current medical practice and modify its policy of permitting certain services to be excluded from the SNF PPS only if they previously were provided in a hospital. Many medications, testing, and procedures now are administered or conducted, respectively, in outpatient settings. CMS should permit these services to be excluded if they are provided in sites other than hospitals and because the definition of SNF services has not changed; and • SNFs and Certified Public Accounting (CPA) firms preparing Consolidated Billing report substantial backlogs and notable contradictory CMS interpretations of excluded and non-excluded items. CMS should investigate challenges with Consolidated Billing and related CMS decision-making in keeping with its Patients Over Paperwork Simplifying Documentation Requirements effort. Subsequently, the Agency should take steps to streamline Consolidated Billing to aid with SNF cash flow.

General Position Statement

CMS has interpreted its statutory Consolidated Billing authority in too restrictive a manner both with the four exclusion categories as well as in regard to the definition of "a resident of a skilled nursing facility," which has site of service implications. These interpretations have not allowed CMS to keep pace with advances in medical technology, primarily medications, and a shift to greater use of outpatient settings.

Background

As enacted by Section 4432(b) of the Balanced Budget Act of 1997 (BBA, P.L. 10533), the original list of exclusions (at section 1888(e)(2)(A)(ii) of the Act) carved out entire categories of services from consolidated billing – primarily, those of physicians and certain other types of medical practitioners. These excluded services are separately billable to the Part B carrier.

Subsequently, Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) enacted a second, more targeted set of exclusions (at section 1888(e)(2)(A)(iii) of the Act), carving out individual "high-cost, low probability"

services within a number of broader service categories – such as chemotherapy services – that otherwise remained subject to consolidated billing.

In this section, AHCA responds to CMS' request for comment on consolidated billing.

1. CMS Consolidated Billing Authority too Narrowly Interpreted.

The Association believes CMS has taken a narrow interpretation of its Consolidated Billing Authority. In Section 1888(A)(2) (iii) (III), (IV), and (V), the statute discusses a list of services and items that are excluded from Consolidated Billing as per the BBRA. However, each clause includes language that allows the Secretary to expand the list of services and items (see bold and italicized text):

- Section 1888(A)(2)(iii)(III): Chemotherapy administration services (identified as of July 1, 1999, by HCPCS codes 36260-36262, 36489, 36530-36535, 36640, 36823, and 96405-96542 (***and as subsequently modified by the Secretary***)) and any additional chemotherapy administration services ***identified by the Secretary***

- Section 1888(A)(2)(iii)(IV): Radioisotope services (identified as of July 1, 1999, by HCPCS codes 79030-79440 (***and as subsequently modified by the Secretary))*** and any additional radioisotope services identified by the Secretary

- Section 1888(A)(2)(iii)(IV): Customized prosthetic devices (commonly known as artificial limbs or components of artificial limbs) under the following HCPCS codes (as of July 1, 1999, (***and as subsequently modified by the Secretary***)), and any additional customized prosthetic devices identified by the Secretary, if delivered to an inpatient for use during the stay in the skilled nursing facility and intended to be used by the individual after discharge from the facility: L5050-L5340, L5500- L5611, L5613-L5986, L5988, L6050-L6370, L6400-L6880, L6920-L7274, and L7362-7366

An AHCA legal analysis indicates the language noted above allows the Secretary to expand the list of services and items added by the BBRA. Since enactment of the BBRA, medical practice greatly has expanded the list of high-cost, low probability medications (items) now being administered in SNFs and other outpatient settings (services). At the same time, the FDA has added approximately 180 chemotherapy medications to its approved schedule. See ***Table 1***, below.

2. Rationale for Expansion and Potential Items.

In at least two respects, CMS is not using its existing authority with respect to consolidated billing to the fullest extent permitted by statute.

a. The "additional" items subclauses have not been fully utilized

CMS's narrow interpretation of the discretionary authority provided by Social Security Act § 1888(e)(2)(A)(iii)(II) to (V) – which grants the Secretary authority to exclude from consolidated billing "additional" chemotherapy items, "additional" chemotherapy administration services, "additional" radioisotope services, and "additional" customized prosthetic devices – is based on a selective reading of legislative history, not the statute itself.

The language of subclauses (II) to (V) was added by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), P.L. 106-113, app. F, § 103(a)(2), 113 Stat. 1501, 1501A-325. Of central importance here, the Conference Committee report that accompanied the BBRA states, in relevant part:

"The agreement includes the House provision. The parties to the agreement include this provision in recognition that skilled nursing facilities (SNFs) from time to time experience high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment they receive under the prospective payment system (PPS). This provision is an attempt to exclude from the PPS certain services and costly items that are provided infrequently in SNFs. For example, in the case of chemotherapy drugs, Health Care Financing Administration (HCFA) physicians excluded specific chemotherapy drugs from the PPS because these drugs are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer. Some chemotherapy drugs, which are relatively inexpensive and are administered routinely in SNFs, were excluded from this provision.

The parties to the agreement recognize that excluding services or items from the PPS by specifying codes in legislation may not be the most appropriate way to protect SNFs from extraordinary events. Additionally, some items may have been inadvertently excluded from the list. New, extremely costly items may come into use or codes may change over time. Therefore, the parties to the agreement expect the Secretary to use her authority to review periodically and modify, as needed, the list of excluded services and items to reflect changes in codes and developments in medical technology …" (H.R. Rep. No. 106-479, at 854 (1999) (Conf. Rep.) (emphases added))."

CMS has consistently cited the Conference Committee report's "high-cost, low probability" language in arguing that it supposedly establishes a mandatory two-part test that limits the Secretary's discretion to identify "additional" items under subclauses (II) to (V). *Compare, e.g.*, SNF PPS Proposed Rule for FY 2001, 65 Fed. Reg. 19,188, 19,232 (Apr. 10, 2000) (citing the Conference Committee report and arguing that it targets "high-cost, low probability" events), *with* SNF PPS Proposed Rule for FY 2019, 83 Fed. Reg. 21,018, 21,033 (May 8, 2018) (repeating same assertion and asserting that CMS will only identify "additional" items if they are both "high-cost" and "low probability").

There are at least two defects in CMS' position. First, the language of the statute controls, not the language of the Conference Committee report. *See, e.g.*, *Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 649 (1990) ("[The] language of a statute – particularly language expressly granting an agency broad authority – is not to be regarded as modified by examples set forth in the legislative history."). Subclauses (II) to (V) do not contain any language limiting the Secretary's discretion to identify "additional" items and services, save for the requirement that the items or services in question must also fall within the category of chemotherapy items, chemotherapy administration services, radioisotope services, or customized prosthetic devices.

Second, even if one assumed that the language of the Conference Committee report limits the Secretary's discretion as a matter of law, CMS' position disregards language in the Conference Committee report that supports the conclusion that Congress intended to grant the Secretary discretion to exclude such "additional" items and services if they are extremely costly or they are not routinely provided in SNFs. *See also* 145 Cong. Rec. S15053 (daily ed. Nov. 19, 1999) (statement of Sen. Moynihan) (expressing support for the legislation because it "exclud[es] certain high-cost items from consolidated billing," and not mentioning any requirement that the items also be low probability). And just because CMS has been wrong for almost 20 years does not mean that CMS cannot reverse course now. *See, e.g.*, *S.E. Ala. Med. Ctr. v. Sebelius*, 572 F.3d 912, 920 (D.C. Cir. 2009) ("HHS does point out that it has counted postage costs toward the [labor-related proportion of the hospital wage index] since the [I]PPS system was first established [in 1983]. But that is history, not explanation. No matter how consistent its past practice, an agency must still explain why that practice comports with the governing statute and reasoned decision-making").

Moreover, CMS has largely ignored the Conference Committee report's language regarding "developments in medical technology." It is well-established that patients now are discharged from hospitals and receiving chemotherapy and other high-cost medical treatments in SNFs that was not the case 20 years ago. These changes provide further support for CMS to change course.

b. Defining "resident of a skilled nursing facility" has been narrowly interpreted

From the very beginning of its implementation of the SNF consolidated-billing requirement, CMS has interpreted the statutory language "resident of a skilled nursing facility" so as to exclude from consolidated billing certain outpatient services that a beneficiary receives from a hospital. *See* 1998 Interim Final Rule, 63 Fed. Reg. 26,252, 26,297–99 (May 12, 1998). To be excluded, the services must be those that "CMS designates as being beyond the general scope of SNF comprehensive care plans …" 42 C.F.R. § 411.15(p)(3)(iii). In justifying this exception, CMS explained that such services are those that,

"under commonly accepted standards of medical practice, lie exclusively within the purview of hospitals rather than SNFs, [and] are not subject to SNF Consolidated

Billing, but are instead bundled to the hospital (for example cardiac catheterization, CT scans, magnetic resonance imaging, [and] ambulatory surgery involving the use of an operating room) (1998 Interim Final Rule, 63 Fed. Reg. at 26,298–99 (emphasis added)).”

However, CMS has persistently refused to expand the exception to include the same category of services if they are provided in a non-hospital setting, such as MRIs provided in freestanding imaging centers. *See, e.g.*, Final Rule Responding to Comments Received on 1998 Interim Final Rule, 64 Fed. Reg. 41,644, 41,675–76 (July 30, 1999) (rejecting request to expand exception); SNF PPS Final Rule for FY 2001, 65 Fed. Reg. 46,770, 47,790 (July 31, 2000) (rejecting request to expand exception using the “additional” items language added by the BBRA, discussed above); and SNF PPS Final Rule for FY 2004, 68 Fed. Reg. 46,036, 46,061 (Aug. 4, 2003) (rejecting request to expand exception); SNF PPS Final Rule for FY 2006, 70 Fed. Reg. 45,026, 45,049 (Aug. 4, 2005) (same).

In rejecting requests to expand the exception to include services provided in a non-hospital setting, CMS has harkened back to its original “lie exclusively within the purview of hospitals” explanation for the exception. *See, e.g.*, SNF PPS Final Rule for FY 2004, 68 Fed. Reg. at 46,061; and SNF PPS Final Rule for FY 2006, 70 Fed. Reg. at 45,049. CMS also has responded to requests to expand the exception by essentially threatening to narrow the exception to the detriment of SNFs, stating:

“*[T]o the extent that advances in medical practice over time may make it feasible to perform such a service more widely in a less intensive, non-hospital setting, this would not argue in favor of unbundling the non-hospital performance of the service under these regulations, but rather, of considering whether to rebundle the service entirely back to the SNF.” (SNF PPS Final Rule for FY 2004, 68 Fed. Reg. at 46,061; see also SNF PPS Final Rule for FY 2006, 70 Fed. Reg. at 45,049 (making similar threat).”*

From a statutory standpoint, the ultimate defect in CMS’ argument is that the basis for the exception – the statutory language “resident of a skilled nursing facility” – is subject to broad interpretation. If CMS truly wanted to expand the exception to include such things as MRIs provided in non-hospital settings, nothing in the statute would preclude it from doing so.

3. AHCA Recommendations.

We believe the Agency has the statutory authority to go well beyond its current interpretation. Below, we offer responses to CMS’ invitation to submit items within the four exclusion categories as well as items we believe also could be excluded based upon the legal analysis, above.

a. AHCA research revealed an extensive list of chemotherapy medications that should be added to the exclusions list.

In response to CMS' request, AHCA offers the list below as additions to the exclusions list using the authority described, above.

Table 1. FDA Chemotherapy Drugs Approved Later Than 1999.

Year	Code	Initial In-Use Date of the HCPCS Code	Description
2004	J9130	01/01/2004	Dacarbazine, 100 mg
2005	J9035	01/01/2005	Injection, bevacizumab, 10 mg
2005	J9041	01/01/2005	Injection, bortezomib, 0.1 mg
2005	J9055	01/01/2005	Injection, cetuximab, 10 mg
2005	J9305	01/01/2005	Injection, pemetrexed, 10 mg
2006	J8515	01/01/2006	Cabergoline, oral, 0.25 mg
2006	J8520	01/01/2006	Capecitabine, oral, 150 mg
2006	J8521	01/01/2006	Capecitabine, oral, 500 mg
2006	J8540	01/01/2006	Dexamethasone, oral, 0.25 mg
2006	J8597	01/01/2006	Antiemetic drug, oral, not otherwise specified
2006	J9025	01/01/2006	Injection, azacitidine, 1 mg
2006	J9027	01/01/2006	Injection, clofarabine, 1 mg
2006	J9175	01/01/2006	Injection, Elliotts' B solution, 1 ml
2007	J9261	01/01/2007	Injection, nelarabine, 50 mg
2007	J9264	01/01/2007	Injection, paclitaxel protein-bound particles, 1 mg
2008	J9225	01/01/2008	Histrelin implant (Vantas), 50 mg
2008	J9226	01/01/2008	Histrelin implant (Supprelin LA), 50 mg
2008	J9303	01/01/2008	Injection, panitumumab, 10 mg
2009	J8705	01/01/2009	Topotecan, oral, 0.25 mg
2009	J9000	01/01/2009	Injection, doxorubicin hydrochloride, 10 mg
2009	J9015	01/01/2009	Injection, aldesleukin, per single use vial
2009	J9017	01/01/2009	Injection, arsenic trioxide, 1 mg
2009	J9040	01/01/2009	Injection, bleomycin sulfate, 15 units
2009	J9045	01/01/2009	Injection, carboplatin, 50 mg
2009	J9050	01/01/2009	Injection, carmustine, 100 mg
2009	J9098	01/01/2009	Injection, cytarabine liposome, 10 mg
2009	J9100	01/01/2009	Injection, cytarabine, 100 mg
2009	J9120	01/01/2009	Injection, dactinomycin, 0.5 mg
2009	J9150	01/01/2009	Injection, daunorubicin, 10 mg
2009	J9160	01/01/2009	Injection, denileukin diftitox, 300 micrograms
2009	J9165	01/01/2009	Injection, diethylstilbestrol diphosphate, 250 mg
2009	J9181	01/01/2009	Injection, etoposide, 10 mg
2009	J9190	01/01/2009	Injection, fluorouracil, 500 mg
2009	J9206	01/01/2009	Injection, irinotecan, 20 mg
2009	J9207	01/01/2009	Injection, ixabepilone, 1 mg
2009	J9209	01/01/2009	Injection, mesna, 200 mg
2009	J9211	01/01/2009	Injection, idarubicin hydrochloride, 5 mg
2009	J9214	01/01/2009	Injection, interferon, alfa-2b, recombinant, 1 million units

Year	Code	Initial In-Use Date of the HCPCS Code	Description
2009	J9215	01/01/2009	Injection, interferon, alfa-N3, (human leukocyte derived), 250,000 IU
2009	J9216	01/01/2009	Injection, interferon, gamma 1-b, 3 million units
2009	J9230	01/01/2009	Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg
2009	J9266	01/01/2009	Injection, pegaspargase, per single dose vial
2009	J9268	01/01/2009	Injection, pentostatin, 10 mg
2009	J9270	01/01/2009	Injection, plicamycin, 2.5 mg
2009	J9310	01/01/2009	Injection, rituximab, 100 mg
2009	J9320	01/01/2009	Injection, streptozocin, 1 gram
2009	J9330	01/01/2009	Injection, temsirolimus, 1 mg
2009	J9340	01/01/2009	Injection, thiotepa, 15 mg
2009	J9355	01/01/2009	Injection, trastuzumab, 10 mg
2009	J9357	01/01/2009	Injection, valrubicin, intravesical, 200 mg
2009	J9360	01/01/2009	Injection, vinblastine sulfate, 1 mg
2009	J9390	01/01/2009	Injection, vinorelbine tartrate, 10 mg
2009	J9600	01/01/2009	Injection, porfimer sodium, 75 mg
2009	Q0166	01/01/2009	Granisetron hydrochloride, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitu...
2010	J9155	01/01/2010	Injection, degarelix, 1 mg
2010	J9171	01/01/2010	Injection, docetaxel, 1 mg
2010	J9328	01/01/2010	Injection, temozolomide, 1 mg
2011	J9060	01/01/2011	Injection, cisplatin, powder or solution, 10 mg
2011	J9302	01/01/2011	Injection, ofatumumab, 10 mg
2011	J9307	01/01/2011	Injection, pralatrexate, 1 mg
2011	J9315	01/01/2011	Injection, romidepsin, 1 mg
2012	J9043	01/01/2012	Injection, cabazitaxel, 1 mg
2012	J9179	01/01/2012	Injection, eribulin mesylate, 0.1 mg
2012	J9228	01/01/2012	Injection, ipilimumab, 1 mg
2012	Q0162	01/01/2012	Ondansetron 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV an...
2013	G8975	01/01/2013	Documentation of medical reason(s) for patient having a hemoglobin level < 10 g/dl (e.g., patients who have non-renal et...)
2013	J9019	01/01/2013	Injection, asparaginase (Erwinaze), 1, 000 IU
2013	J9042	01/01/2013	Injection, brentuximab vedotin, 1 mg
2013	J9280	01/01/2013	Injection, mitomycin, 5 mg
2014	J8562	01/01/2014	Fludarabine phosphate, oral, 10 mg
2014	J9047	01/01/2014	Injection, carfilzomib, 1 mg
2014	J9178	01/01/2014	Injection, epirubicin HCl, 2 mg
2014	J9201	01/01/2014	Injection, gemcitabine hydrochloride, 200 mg
2014	J9212	01/01/2014	Injection, interferon alfacon-1, recombinant, 1 microgram

Year	Code	Initial In-Use Date of the HCPCS Code	Description
2014	J9262	01/01/2014	Injection, omacetaxine mepesuccinate, 0.01 mg
2014	J9306	01/01/2014	Injection, pertuzumab, 1 mg
2014	J9354	01/01/2014	Injection, ado-trastuzumab emtansine, 1 mg
2014	J9371	01/01/2014	Injection, vincristine sulfate liposome, 1 mg
2014	J9395	01/01/2014	Injection, fulvestrant, 25 mg
2014	J9400	01/01/2014	Injection, ziv-aflibercept, 1 mg
2014	Q0161	01/01/2014	Chlorpromazine hydrochloride, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic subst...
2015	J8565	01/01/2015	Gefitinib, oral, 250 mg
2015	J9267	01/01/2015	Injection, paclitaxel, 1 mg
2015	J9301	01/01/2015	Injection, obinutuzumab, 10 mg
2016	G0498	01/01/2016	Chemotherapy administration, intravenous infusion technique initiation of infusion in the office/clinic setting using o...
2016	J8655	01/01/2016	Netupitant 300 mg and palonosetron 0.5 mg
2016	J9020	01/01/2016	Injection, asparaginase, not otherwise specified, 10,000 units
2016	J9032	01/01/2016	Injection, belinostat, 10 mg
2016	J9039	01/01/2016	Injection, blinatumomab, 1 microgram
2016	J9271	01/01/2016	Injection, pembrolizumab, 1 mg
2016	J9299	01/01/2016	Injection, nivolumab, 1 mg
2016	J9308	01/01/2016	Injection, ramucirumab, 5 mg
2017	G9826	01/01/2017	Patient transferred to practice after initiation of chemotherapy
2017	G9829	01/01/2017	Breast adjuvant chemotherapy administered
2017	G9833	01/01/2017	Patient transfer to practice after initiation of chemotherapy
2017	G9836	01/01/2017	Reason for not administering trastuzumab documented (e.g. patient declined, patient died, patient transferred, contraind...
2017	G9847	01/01/2017	Patient received chemotherapy in the last 14 days of life
2017	G9848	01/01/2017	Patient did not receive chemotherapy in the last 14 days of life
2017	J8501	01/01/2017	Aprepitant, oral, 5 mg
2017	J8530	08/31/2017	Cyclophosphamide oral, 25 mg
2017	J8670	01/01/2017	Rolapitant, oral, 1 mg
2017	J9033	01/01/2017	Injection, bendamustine HCL (treanda), 1 mg
2017	J9034	01/01/2017	Injection, bendamustine HCL (bendeka), 1 mg
2017	J9145	01/01/2017	Injection, daratumumab, 10 mg
2017	J9176	01/01/2017	Injection, elotuzumab, 1 mg
2017	J9205	01/01/2017	Injection, irinotecan liposome, 1 mg
2017	J9218	01/01/2017	Leuprolide acetate, per 1 mg
2017	J9295	01/01/2017	Injection, necitumumab, 1 mg

Year	Code	Initial In-Use Date of the HCPCS Code	Description
2017	J9325	01/01/2017	Injection, talimogene laherparepvec, per 1 million plaque forming units
2017	J9352	01/01/2017	Injection, trabectedin, 0.1 mg
2018	C9463	04/01/2018	Injection, aprepitant, 1 mg
2018	C9464	04/01/2018	Injection, rolapitant, 0.5 mg
2018	J8510	01/01/2018	Busulfan oral, 2 mg
2018	J8650	01/01/2018	Nabilone, oral, 1 mg
2018	J8700	01/01/2018	Temozolomide, oral, 5 mg
2018	J9151	01/01/2018	Injection, daunorubicin Citrate, liposomal formulation, 10 mg
2018	J9185	01/01/2018	Injection, fludarabine phosphate, 50 mg
2018	J9200	01/01/2018	Injection, floxuridine, 500 mg
2018	J9208	01/01/2018	Injection, ifosfamide, 1 gram
2018	J9213	01/01/2018	Injection, interferon, alfa-2a, recombinant, 3 million units
2018	J9219	01/01/2018	Leuprolide acetate implant, 65 mg
2018	J9263	01/01/2018	Injection, oxaliplatin, 0.5 mg
2018	J9351	01/01/2018	Injection, topotecan, 0.1 mg

Recommendation: *CMS should add the medications listed above to the exclusions list or explain why these medications are not appropriate for the exclusions list.*

b. CMS also has the authority to broaden exclusions when medications are now considered part of drug regimen services. The agency has used this interpretation before in ESRD.

CMS also asks for recommended additions to the exclusions chemotherapy administration services list. CMS interprets the BBRA to prohibit it from excluding antineoplastic antiemetics and supportive medications which, while not chemotherapeutic agents in themselves, are necessary to the treatment of cancer.

Antiemetics are those high-cost drugs used to treat the extreme nausea caused by chemotherapy and not general antiemetics used for other types of nausea. These drugs represent standards of care in oncology practice and are considered part of the chemotherapy regimen, *or as part of chemotherapy services*, by oncologists. Supportive medications maintain blood cells, rescue healthy cells from toxic effects of antineoplastic drugs, and counteract the effects of cancer disease processes that spill over to other, nonmalignant organ systems (example: zoledronic acid to treat bone lesions affected by solid tumors).

To exclude chemotherapy from consolidated billing without excluding the drugs and biologicals needed in conjunction with this service is to place a financial burden on SNFs, as their costs far exceed the payment received under the PPS and fails to

incorporate chemotherapy services as characterized in modern oncology, which significantly impacts Medicare beneficiaries battling cancer.

In this line of thinking, we note that CMS has identified certain products related to ESRD by excluding certain drugs such as Aranesp, [darbepoetin Alfa] HCPCS J0882, when used for ESRD residents. This is excluded because it falls within the general scope of coverage within the Social Security Act at 1861(s)(2)(F):

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies, and, for items and services furnished on or after January 1, 2011, renal dialysis services (as defined in section 1881(b)(14)(B)), including such renal dialysis services furnished on or after January 1, 2017, by a renal dialysis facility or provider of services paid under section 1881(b)(14) to an individual with acute kidney injury (as defined in section 1834(r)(2));[396]

Recommendation for Clarification: *We request clarification in regard to why CMS policy related to ESRD exclusions using the authority above is not used for chemotherapy exclusions.*

c. Site of Service Consolidated Billing Rule Has Not Kept Pace with Modern Medical Practice

As indicated above, we believe CMS has too narrowly interpreted "resident of a skilled nursing facility." CMS has excluded MRIs, CT scans, ambulatory surgery involving the use of an operating room, cardiac catheterization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures. However, in order to be excluded from PPS, the services must be provided in a hospital. If they are provided in a freestanding clinic, such as a radiation therapy clinic or imaging center, they are not excluded.

In 1998, the advent of PPS, CMS was reflecting then current medical practice in its development of the regulatory PPS exclusions. However, medical practice has changed, and the services in question are no longer exclusively within the purview of hospitals. Radiation therapy is now commonly provided in freestanding radiation therapy clinics, and MRIs are available from freestanding entities. Use of freestanding ambulatory surgery clinics have also been expanding. And these services are not discussed as SNF services at Section 1819(a).

Complicating matters, most hospitals have subcontracted out operation of hospital campus-based imaging and radiation therapy departments to unaffiliated third-party organizations. This has made it very difficult for SNFs to understand whether or not the services being provided to their patients in the hospital are subject to consolidated billing or not.

AHCA has requested that CMS examine current medical practice and modify its policy of permitting certain services to be excluded only if provided in a hospital but not if provided suitably and appropriately in sites other than hospitals, chiefly freestanding clinics. This policy change should be considered, at a minimum, for ambulatory surgery, MRIs, and radiation therapy services.

CMS created its exclusion policy based on two factors:

- That these services (MRIs, CT scans, ambulatory surgery involving the use of an operating room, cardiac catheterization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures) that patients could receive while in a SNF Part A stay were outside the scope of SNF services; and,
- That at the time of implementation of the PPS, these were "intensive diagnostic or invasive procedures that [were] specific to the hospital setting." 63 Federal Register 26298, May 12, 1998.

With regard to the second prong, in the final rule for FY 2006, CMS indicated the exclusion of certain outpatient hospital services "… is targeted specifically at those services … that, under commonly accepted standards of medical practice, lie *exclusively* within the purview of hospitals … that is, services which generally require the intensity of the hospital setting in order to be furnished safely and effectively." 70 Federal Register 45026 at 45049, August 4, 2005.

However, the second test should be modified to account for modern medical practice and changes in the health care marketplace. MRIs and radiation therapy services are now being furnished safely and effectively in freestanding clinics. And, CMS' Medicare modernization efforts have fostered further movement of certain tests and procedures to settings outside of hospitals. Additionally, traditional hospitals have transformed into health care systems no longer defined by a single building.

d. Streamlining and Clarifying CMS Procedures and Policy.

SNFs and contracted CPA firms report backlogs in CMS review and processing of Consolidated Billing, often with contradictory responses. At the same time, CMS leadership has embraced the Patients Over Paperwork Effort and, as part of that effort, its Simplifying Documentation Requirements work. To date, CMS has clarified or eliminated unnecessary barriers to provider payment. Below, we offer examples from CMS' Simplifying Documentation Requirements web page (***Table 2,*** below).

Table 2. Examples of CMS' Simplifying Documentation Requirements Policy Changes

CMS Action	Environment Before	Environment After
Clarified proof of delivery (POD) requirements	The Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) help CMS oversee the DME	New guidance advises MACs to request proof of delivery documentation for DME items only if it is required as a condition of

CMS Action	Environment Before	Environment After
	benefit. Some DME MACs were routinely auditing suppliers for proof of delivery for every claim they reviewed. Suppliers maintain proof of delivery but often fail to meet a technical requirement necessary for compliance.	payment, for example, as a written order prior to delivery for Power Mobility Devices. The guidance also simplifies CMS documentation instructions. While suppliers are still required to keep proof of delivery for every item they bill, and may be requested to provide such documentation to other review entities, this should reduce the amount of paperwork suppliers are required to submit to MACs during medical review.
Clarified medical review of inpatient rehabilitation facility (IRF) claims	IRF claims were denied even though patients needed and could benefit from an inpatient rehabilitation program.	CMS clarified guidance to its contractors, requiring them to use clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not based on any threshold of therapy time.

Recommendation: *CMS should investigate challenges with Consolidated Billing submissions and related CMS decision-making in keeping with its Patients Over Paperwork Simplifying Documentation Requirements effort. Subsequently, the Agency should take steps to streamline Consolidated Billing processing to aid with SNF cash flow and clarify policies to reduce lost time in paperwork when such resources could be diverted to funding high-quality patient care.*

Section 3: Patient-Driven Payment Model (PDPM)

AHCA supports modernizing the Medicare SNF PPS. To that end, AHCA has participated in CMS Technical Expert Panels (TEPs), submitted extensive comments to aid in the development of a new SNF PPS, and has shared an array of ideas and insights with CMS staff in the spirit of collaboration. We appreciate CMS' responsiveness to-date in improving the payment model design in response to public feedback and comments. And, AHCA looks forward to continued collaboration as CMS would do so with any stakeholder group on PDPM.

However, AHCA believes several PDPM design issues remain and must be addressed before implementation. The Association believes that without appropriate attention, these items will negatively impact transition from Resource Utilization Group Version IV System (RUG-IV) to PDPM and create significant challenges for CMS, providers, and beneficiaries. Due to these concerns, we urge CMS to exercise extreme caution when considering finalization of any PDPM provisions in the final FY19 rule until these issues are thoroughly addressed.

We offer these comments collegially and in hopes of ensuring a stable and smooth transition from RUG-IV to PDPM. AHCA also looks forward to the opportunity for stakeholder input on these points in a transparent and ongoing manner. In Section 3, for each subsection, we offer an overarching statement, detailed discussion, and suggested solutions and/or requests for clarification. In ***Table 1***, below, we offer our key PDPM priorities.

Table 1 – AHCA Top Comments on PDPM

Broad Challenge	Specific PDPM Concerns	Recommended Solution &/or Request for Clarification
PDPM Remains Complex – More Can be Done to Reduce Provider Burden	The ***Interim Payment Assessment (IPA)*** proposal is unnecessarily complicated and would require more staff attention to process rather than delivering patient care	• IPA as proposed creates new SNF burden • CMS should clarify what patient characteristic changes trigger an IPA • Thresholds should be set in IPA policy for NTAS to be reset to Day 1 in certain scenarios
	The proposed Use of multiple ***ICD-10-CM or PCS Codes*** on MDS for resident classification is not required by HIPAA as part of a "transaction" and would be a significant challenge for SNFs and would offset any perceived burden relief benefit from the proposed elimination of the current MDS and Other Medicare Required Assessments (OMRA)	• ICD-10 codes are not essential nor required on the admission MDS for resident classification and AHCA offers an alternative approach • SNFs still will be required to update clinical assessments in order to maintain an up-to-date Comprehensive Person-Centered Plan of Care • OBRA required assessments continue
	Reporting ***therapy minutes*** on the discharge MDS and claims is redundant	• AHCA strongly opposes the reporting of therapy services in Section O of the SNF PPS Discharge MDS under PDPM as proposed. • AHCA recommends an alternative solution where the reporting of similar information of therapy services on claims better serves to achieve the CMS intent while limiting provider burden. • AHCA recommends that in evaluating the impact of PDPM implementation on therapy service delivery patterns, CMS must do so in the context of the impact on CMS-developed quality and outcomes measures that are commonly associated with effective rehabilitation services

	Non-Therapy Ancillary Services (NTAS) component carries the current disincentives to admitting high-cost, medically complex patients into PDPM	• AHCA offers two solutions to address interaction of the NTAS component tapering with assessment proposals:
		  ○ Initial/Admission Assessment – Build on the Existing RAI Modification Provision and Lengthen 5-Day Assessment Window
		  ○ Develop an IPA Threshold for NTAS Reset to Day One
		• Clarification is needed on
		  ○ Changes to the Conditions and Extensive Services list in PDPM relative to the RCS-1 list; and

Table 1 – AHCA Top Comments on PDPM

Broad Challenge	Specific PDPM Concerns	Recommended Solution &/or Request for Clarification
System Stability and Beneficiary Access is a Concern – CMS Appears to have Created New Beneficiary Challenges		○ Explanation of how high-cost conditions and extensive services will be paid for that are not on the list. AHCA suggests the creating of a default category and related rate development concept.
	The ***Interrupted Stay Policy and the inability to reset NTAS*** creates a payment system incentive which runs counter to other SNF programs and policies and could create beneficiary issues	• AHCA supports an interrupted stay policy but with modification ○ The number of days (</= 3; >3) should not matter, rather the patient condition. SNFs are required to re-assess at admission for care plan development ○ The same parameters as under our IPA proposals could be used • SNFs are subject to a SNF Value-Based Purchasing Program as well as IMPACT Act Quality Reporting Program Measures. CMS should utilize those tools in operationalizing the interrupted stay policy and related monitoring rather than "additional scrutiny"
	CMS has proposed PDPM as ***budget neutral***; however, AHCA analysis indicates a number of concerns with leakage from the payment system that could result in underfunding or overpayment, which in turn could result in unanticipated expenditure growth.	• Short-term and Long-term recalibration strategies are needed ○ Leakage Challenges ▪ Hospital MS-DRG information to set rates likely will result in lower payments than predicted ▪ SNF Charge to Estimated Cost likely will result in underpayment for high-cost cases ▪ Lack of Component Wage Adjustment May Lead to Dropped Services • Potential Overages ▪ Section GG reverses the Section G scoring structure and likely will result in completion challenge and inadvertent errors ▪ Many MDS elements traditionally used only for care planning, including depression, would impact PDPM payment, and changes in usage (appropriate or not) may require monitoring for appropriate recalibration • CMS should engage an ongoing SNF Stakeholder Work Group as it did in the transition from cost-based payment to the RUG-based PPS to address these concerns as well as AHCA's other comments, suggestions, and requests for clarification. Already AHCA has been working with a group of 14 organizations on SNF Payment Reform, which could serve as the basis for such a work group.

Subsection A: Independent Statistical Critique

As in our August 2017 Advanced Notice comments, AHCA offers an independent statistical critique of Acumen methods to which we still find concerns. The Moran Company draft document represents our responses to the current PDPM requests for comment, below.

CMS Request for Comments	The Moran Company Comments In-Brief
Page 21037 – We invite comments on any and all aspects of the proposed PDPM, including the research analyses described in this proposed rule, the SNF PDPM technical report.	- Continued Inappropriate Use of 1995 Cost Report Data - Low Explanatory Power of Model and Lack of Objective Threshold for Inclusion in Model - SNF Charges Have Never Been Tied to Rate-Setting Before - Model Relies on Diagnosis Information Outside Control of the SNF
Page 21040 – We invite comments on the proposed data sources and proposed methodology for calculating the unadjusted federal per-diem rates that would be used in conjunction with the proposed PDPM effective October 1, 2019.	

Critique of Acumen Patient Driven Payment Model Technical Report

June 2018

Critique of Acumen Patient Driven Payment Model Technical Report

Introduction

The American Health Care Association (AHCA) asked The Moran Company (TMC) to perform a peer-review style analysis of the statistical methods, data quality, and underlying assumptions supporting the technical report outlining the design of the Patient Driven Payment Model (PDPM) for skilled nursing facilities (SNFs) under Medicare. This critique reviews the *Skilled Nursing Facilities Patient-Driven Payment Model Technical Report (*Acumen Report) released in April 2018 by Acumen, LLC, under contract to the Centers for Medicare and Medicaid Services (CMS).

Both CMS and Acumen have made substantial efforts to interact with stakeholders on the subject of SNF payment policy revisions, both through multiple technical expert panels (TEPs) and through multiple revisions of potential payment models including Resident Classification System, Version I (RCS-I). As such the PDPM already incorporates stakeholder feedback on many key system design issues. This report outlines the remaining weaknesses in the model so that refinements can continue to be made prior to 2019 implementation of a new payment policy under PDPM.

Using a peer review approach, we focus on areas of potential improvement for the PDPM including:

- Updating Input Data Sources to Reflect Current Clinical Practice
- Objective Thresholds for Inclusion of Variables in PDPM
- Potential Challenges of Using SNF Charges in Rate-setting
- Use of Diagnosis Information Outside the Control of the SNF

Continued Inappropriate Use of 1995 Cost Report Data

Acumen continued to use 1995 cost report data to calculate the original component cost allocation. It builds upon the 1995 data with an implicit assumption that the structure of cost across SNFs between the historic components is valid. However, this is very old data. Cost reporting has changed in significant ways from 1995. Some of the changes to cost reporting are:

- Medicare Advantage (MA) did not exist in 1995 and very limited capitated care was delivered to Medicare Part A beneficiaries in SNFs.
- The original cost reports upon which the SNF PPS components were based included allocation of cost to Medicare certified beds in distinct part units. Cost centers now include cost for all beneficiaries in both SNF and long-term care beds, covered by all payers, across a wider range of services.

- Cost centers for therapy include therapy delivered to Part C patients, Part B therapy delivered to long term care patients, therapy covered by commercial plans and private pay.
- Cost centers for NTAs similarly have never represented an accurate basis for estimating actual NTA cost.

Both clinical practice and facility accounting have changed substantially in the 23 years since the cost reports in question were filed. Absent a robust analysis of current cost reporting by facilities, it is difficult to accept at face value the assertion these data remain relevant. And should the model be updated and re-run in future years, it will continue to diverge further and further from modern clinical and accounting practices at SNFs.

In addition, Acumen used staff-time measurement data from the STRIVE study to develop the resident classification for nursing payment and estimate relative differences in nursing utilization across the nursing groups. However, STRIVE data was collected in 2006-2007 which is more than decade old. Acumen re-estimated wage-weighted staff time using 2016 wage data, but this does not consider any changes in clinical practice since 2006. Again, without providing for an update to this input data, future updates to the PDPM will diverge further and further from actual clinical practice.

Low Explanatory Power of Model and Lack of Objective Threshold for Inclusion in Model

Acumen conducted regression analyses to build payment groups in their model. In some instances, Acumen published comparative analysis of the predictive power of two model options and then selected a model based on the predictive power. R-squared values of components included in the model continue to be extremely low. More troubling, Acumen did not publish an objective threshold of R-squared values for inclusion or exclusion of model features. If CMS intends to update this model with new data over time to reflect changes in clinical practice and resource utilization, there is a need for a systematic determination of the minimum acceptable R-squared values for the model features. Model components currently excluded may increase in predictive power over time and merit inclusion in future versions of the PDPM. In addition, current model components may decrease in predictive power such that they should be removed from the model.

Acumen selected Section GG items for inclusion in the functional measure for the PT and OT components by running individual regressions using each of 12 Section GG functional abilities to separately predict PT and OT costs per day. Two items GG0170R1 (wheel 50 feet with two turns) and GG0170S1 (wheel 150 feet) were excluded due to low predictive ability. However, the range of R-squared values of the remaining ten items are low which range from 0.020 to 0.055. Also, Acumen decided to not include PT and OT comorbidities in the payment model based on the R-squared values. However, the model without the comorbidities that was chosen does not seem to have a substantially higher R-squared value to explain enough variation. Without consistent standards for inclusion it is difficult to predict or understand what future

updates of the PDPM may look like. We note that the decision to split PT and OT groups resulted in the cognitive fuction variable ceasing to have sufficient predictive power and being excluded, just one example of a potential model change without an objective threshold for inclusion.

SNF Charges Have Never Been Tied to Rate-setting Before

Unlike the hospital prospective payment system, charges on claims have never played a significant role in Medicare payment for SNF services, and have never before been used in rate-setting in the SNF context. Charges on claims and CCRs are used to annually re-base the MS-DRG and APC weights and rates in the inpatient and outpatient hospital prospective payment systems. It is these methods that form the basis for Acumen's decision to estimate cost per day based on charges on claims.

Each SNF, like other Medicare providers, must maintain a single charge master which itemizes a wide range of services and assigns a charge to each service it includes on bills. Electronic claims systems compile charges at the revenue code level (lumping different items that share the same revenue code together) in SNF claims and reports them on the claim by revenue code. Few payers actually use charge data to pay for SNF services, and payers that do use charges may be most concerned about itemized charges, not aggregated to the revenue code level (e.g., self pay). There is no government requirement for the source, or basis for constructing, a charge master, and the charge master is not and cannot be audited. Its content is at the discretion of the provider. Within a single revenue code such as "drugs charged to patients", diverse items with highly variable mark-ups may be rolled up: over-the-counter drugs with 100x mark-ups may be included with a $5000 drug marked up by 20%, a phenomenon which has been documented in hospital chargemasters already.

Because charge data are seldom used by payers, and are created at the discretion of the provider, they may not be updated at regular intervals, may contain typographical and other types of errors that do not get picked up for lack of use, or have other variations in quality. In systems where charge data are used only for rate setting purposes, these data are open to manipulation, and because their content are at provider discretion, they are not subject to audit (providers are free to establish any mark-up they want, and their practices are not subject to oversight).

Charges for NTAs represent several distinct standard cost centers. The items that link to these cost centers may be much less homogeneous than the therapy cost centers. Each SNF may have multiple categories of charges linked to revenue codes that can be rolled up to each NTA cost center. However, here too, the SNF may use many different sources of data and concepts to construct its charge master. The major consistent source for NTA cost is pharmaceuticals. SNFs generally contract with clinical pharmacies to deliver pharmaceuticals and various supplies on a daily basis. Each clinical pharmacy has a somewhat different format and schedule for charging the SNF for its products and services. And each SNF business office may have different procedures for booking those charges. Charges include ingredient costs that are marked up by the pharmacy, as well as dispensing fees, administrative/delivery cost, supplies such as IV tubing, other supplies. Sometimes these costs may be broken out, but more often they are aggregated and reported in invoices to the SNF for each patient. Invoices are produced at different intervals depending on the arrangement between the pharmacy and its customers. Charges for these items may be reported on claims in aggregate under a pharmacy revenue code

or by product or service. The charges may or may not match the exact Medicare covered days on the claim, but will provide the number of days for which the drug was prescribed, so there is no auditable requirement that the charges fit the days. What can be reported on a claim may depend on the linkage between the pharmacy's billing cycle for the SNF and the SNF's billing cycle for Medicare, and protocols for reporting data from invoices into the SNF Medicare bill. The charge master may not include itemized mark-ups by product. It may represent a markup on the pharmacy charges in aggregate, or it may pass through the pharmacy charges without mark-up. Because reporting pharmacy charges could lag the actual service dates for claim preparation, there could be a mismatch between the claim and the charges that technically belong to that claim. All of these factors suggest that charges for pharmaceuticals may be limited in specificity to the categories under which a SNF bills commercial payers or patients/families when these services are delivered, the only times when the charge forms any basis for payment.

While these data may be the best available method for estimating cost at a more granular level, we caution that cost reporting and chargemasters may change materially in response to their use in setting rates. As such, key assumptions and relationships measured in the PDPM may need to be revisited in future updates of the PDPM when the resulting changes can be quantified in future charge and cost data. This includes the decision to include or exclude various model components.

Model Sets Rates Based Upon Hospital Coding Rather than MDS Coding

As in RCS-I, the model relies upon MS-DRGs to map patients to clinical categories. While Acumen evaluated the quality of potential SNF diagnosis data for its use in PDPM, they found it to be insufficient for use due to the prevalence of "generic" ICD-9 codes which lacked sufficient specificity in assigning patients to clinical categories. This is a key piece of information which Acumen did not evaluate for its correlation with the SNF MDS data upon which actual clinical classifications will be based. SNFs do not diagnose patients and rely upon treating physicians, hospitals, and self/family reported medical history for diagnosis information. If SNF MDS coding produces a substantially different set of case-mix adjustments from the case-mix derived from hospital DRG assignments, then the model will produce inappropriate payment rates for the cases which deviate from the "predicted" case mix rate.

Stable and predictable payment rates are essential to operations for facilities, which makes the reliance upon hospital data in the model challenging. CMS should consider retroactively evaluating this case-mix adjustment as soon as it has SNF data following PDPM implementation. Once the case-mix deviation between the Acumen model and the implementation model can be determined in post-PDPM claims data, CMS can correct any inaccurate payments in future updates of the PDPM. Because the clinical categorizations are integral to the PDPM, this comparative analysis should be conducted as soon as the data becomes available.

Conclusion

We have identified a number of technical concerns related to data quality and methodology, primarily as it relates to the updating of the PDPM over time. In many cases Acumen has made use of the best available data but has not considered or modeled changes in the underlying data over time. As such, key assumptions in model design may need to be revisited as more current data becomes available. It is especially crucial that input data into the model reflect current clinical practice so that resulting payment rates accurately describe the resources needed to deliver care to SNF patients.

Section B. Revision of Case-Mix Methodology

NPRM Comment Request	AHCA Comments
Page 21040 – We invite comments on the proposed data sources and proposed methodology for calculating the unadjusted federal per-diem rates that would be used in conjunction with the proposed PDPM effective October 1, 2019.	
- AHCA recommends that CMS reassess the methodology used to determine the proposed PDPM Unadjusted Federal Urban and Rural Per Diem Rates to assure that the dollars associated with the RUG-IV Therapy-Non-Case-Mix component are appropriately distributed among the PDPM PT, OT, and SLP components.	

General Position Statement

AHCA believes there may have been an error in the determination of the proposed FY 2019 PDPM Unadjusted PT, OT, and SLP Federal Urban and Per Diem rates reflected in NPRM Tables 12 and 13, which would require correction before finalization to assure that RUG-IV Therapy-Non-Case-Mix dollars are not leaked from the PDPM model.

a. CMS Proposal

CMS describes the proposed process taken to revise the SNF PPS Federal Base Payment Rate Components in Subsection V.C of the NPRM (pages 21037-21040). Specifically, CMS describes the process to transition from four rate components under the RUG-IV SNF PPS to six rate components under the proposed PDPM system.

With regards to the therapy components, CMS describes a process of splitting the RUG-IV therapy case-mix (which includes PT, OT, and SLP services combined) into three separate components under PDPM. CMS also describes (NPRM page 21037) an intent to eliminate the RUG-IV Therapy-Non-Case-Mix component and reallocate those dollars proportionally among the PDPM PT, OT, and SLP components as described below:

> *"…as part of the PDPM case-mix model, we propose to … separate the ''therapy case-mix'' component of the federal base payment rate into three case-mix adjusted components …. More specifically, we propose to separate the ''therapy case-mix'' rate component into a ''Physical Therapy'' (PT) component, ''Occupational Therapy'' (OT) component, and a ''Speech-Language Pathology'' (SLP) component …. Given that all SNF residents under PDPM would be assigned to a classification group for each of the three proposed therapy-related case-mix adjusted components as further discussed below, we propose eliminating the ''therapy non-case-mix'' rate component under PDPM and distributing the dollars associated with this current rate component amongst the proposed PDPM therapy components."*

b. AHCA Recommendation

AHCA believes there may have been an error in the determination of the proposed FY 2019 PDPM Unadjusted PT, OT, and SLP Federal Urban and Per Diem rates reflected in

NPRM Tables 12 and 13, which would require correction before finalization to assure that RUG-IV Therapy-Non-Case-Mix dollars are not leaked from the PDPM model.

Specifically, we note that on Tables 4 and 5 of the NPRM (page 21023) posted below, the sum of the FY 2019 unadjusted RUG-IV federal per-diem rate for the therapy-case-mix and therapy-non-case-mix columns for urban and rural are $154.72 and $176.88 respectively.

TABLE 4—FY 2019 UNADJUSTED FEDERAL RATE PER DIEM—URBAN

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$181.50	$136.71	$18.01	$92.63

TABLE 5—FY 2019 UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	Nursing—case-mix	Therapy—case-mix	Therapy—non-case-mix	Non-case-mix
Per Diem Amount	$173.39	$157.65	$19.23	$94.34

However, we note that on Tables 12 and 13 of the NPRM (page 21040) posted below, the sum of the FY 2019 unadjusted PDPM federal per-diem rate for the PT, OT, and SLP case-mix columns for urban and rural are $136.71 and $157.64 respectively. These totals appear to reflect only the RUG-IV therapy case mix component dollars, and represent a leakage per-diem shortfall of $18.01 and $19.23 for the respective urban and rural therapy case-mix rates, or approximately $1 billion in aggregate.

TABLE 12—FY 2019 PDPM UNADJUSTED FEDERAL RATE PER DIEM—URBAN [3]

Rate component	Nursing	NTA	PT	OT	SLP	Non-case-mix
Per Diem Amount	$103.46	$78.05	$59.33	$55.23	$22.15	$92.63

[3] The rates shown in Tables 12 and 13 illustrate what the unadjusted federal per diem rates would be for each of the case-mix adjusted components if we were to apply the proposed PDPM to the proposed FY 2019 base rates given in Tables 4 and 5.

TABLE 13—FY 2019 PDPM UNADJUSTED FEDERAL RATE PER DIEM—RURAL

Rate component	Nursing	NTA	PT	OT	SLP	Non-case-mix
Per Diem Amount	$98.83	$74.56	$67.63	$62.11	$27.90	$94.34

AHCA recommends that CMS reassess the methodology used to determine the proposed PDPM Unadjusted Federal Urban and Rural Per Diem Rates to assure the dollars associated with the RUG-IV Therapy-Non-Case-Mix component are appropriately distributed among the PDPM PT, OT, and SL.

Subsection C. PDPM Compliance and Program Integrity Challenges

AHCA believes the proposed approach to require the submission of multiple fully-specified ICD-10 diagnosis and procedure codes on the MDS for resident classification purposes as the most challenging PDPM feature that requires revision, not only as it relates to provider effort and documentation burden, but for the associated compliance and program integrity challenges it will create. We also believe that the proposed IPA assessment approach needs to be tightened up and limited to more specific clinical situations, otherwise we envision significant challenges with extremely variable medical review misinterpretations. CMS should also align other SNF programs and policies along with the design of this new SNF payment system.

CMS Request for Comment	AHCA Comments In-Brief
Page 21037 – We invite comments on any and all aspects of the proposed PDPM, including the research analyses described in this proposed rule, the SNF PDPM technical report.	• CMS should use the simplest coding approach to reduce the probably of inadvertent coding errors. Use of AHCA's alternative to ICD-10 coding on the 5-Day MDS is an excellent way to reduce potential error. See Subsection G, Attachment A for more detail. • The Interim Payment Assessment (IPA) as currently drafted creates considerable provider risk for error. AHCA has proposed a strategy to reduce this complexity. See Subsection G.

General Position Statement

AHCA recognizes the onus to adapt to PDPM, as well as related systems and operational changes, resides with SNFs and related vendors partners. However, due to the significant change in payment PDPM represents, CMS should modify the proposed policy and take steps with SNF Stakeholders reduce the risk of untended documentation and medical review errors that will increase both SNF and CMS burden. We offer the solutions, below.

AHCA believes new data required for PDPM and related use of such data creates an array of new SNF compliance and CMS Program Integrity challenges. While AHCA strongly believes that fraud against the Federal Government is unacceptable, care should be taken that PDPM is not designed and implemented in such a way as to create a "system of government traps, zaps, and zingers that permits the government to retain the benefit of a substantially conforming good or service but to recover the price entirely – multiplied by three – because of some immaterial contractual or regulatory non-compliance." *United States ex rel. Ruckh v. Salus Rehab., LLC*, No. 8:11-cv-01303, 2018 WL 375720, at *3 (M.D. Fla. Jan. 11, 2018).

1. PDPM Creates Compliance Challenges

While AHCA believes CMS may have addressed many of the current PPS challenges articulated by MedPAC, OIG, and CMS regarding potential incentives for excessive therapy, the proposed payment system would create other unintended compliance challenges. For example, MDS coordinators could feel pressure to code in specific ways.

And, no guidance is offered in the NPRM on how CMS would minimize these risks or ensure coding accuracy.

At a high level, potential PDPM proposed design risks associated with MDS diagnosis coding and claims submissions include:

1. *Not Including All Medical Diagnoses on the Claim and MDS.* The cause for missing medical diagnoses might stem from poor – or uninformed in the case of PDPM – provider coding practices or where diagnoses are captured on the MDS but are not making their way to the claims. Such mismatched data will cause challenges with claims adjudication and SNF audits.

2. *Coding to the most appropriate level of precision in a SNF*. The ICD-10 diagnosis codes can be three to seven characters long, in which the first one to three characters indicate the category of the diagnosis; the fourth to sixth characters indicate etiology, anatomic site, severity, or other clinical detail; and the seventh character indicates extension (such as initial or subsequent counter, etc.). More specific coding, i.e., using more characters to describe the illness, could help with identifying higher severity of the same diagnosis type, which in turn, might lead to a higher, more accurate payment in an acute care setting. But such specificity is not essential on the MDS for identifying the proposed PDPM resident classification conditions and comorbidities necessary for accurate SNF payment. In regard to procedure coding, hospitals have indicated they struggle with correct ICD-10 procedure coding. In particular, hospital representatives have indicated hospitals would be unable to transmit procedure codes to SNFs until several weeks after SNF admission. **We oppose the mandatory use of ICD-10 codes on the MDS for resident classification, particularly procedure codes.**

Recommendation for items 1 & 2: *AHCA has an alternative approach to the mandatory use of multiple fully-specified ICD-10 codes on the MDS, which would mitigate these problems. See Subsection G Attachment A.*

3. *Not coding chronic conditions consistently year over year***.** Chronic conditions, or comorbidities, in SNFs may be coded one year and, yet, inadvertently not show up on an MDS or claim in the following year for a long term care resident moving in and out of post-acute stays or a post-acute care patient with more than one spell of illness. Or, the condition may not be coded the same way as in a prior year. In the first example, by definition, chronic conditions and comorbidities do not resolve themselves within a year. Inconsistent coding likely means that care was given to the patient but the provider did not accurately capture it in the claims submission, leading to unexpected payment changes. In the second scenario, a RAC or other audit entity might determine that a SNF up-coded if subsequent year coding resulted in higher payments. ***Recommendation***: *AHCA requests that CMS clarify about chronic condition coding should be reported and handled by medical reviewer as PDPM is implemented.*

Below, we offer more specific examples of our concerns by PDPM functional area:

- *MDS Reconfiguration Elevates Accurate Completion Importance.* While we appreciate CMS efforts to simplify PDPM relative to RCS-1, we believe PDPM still includes substantial new MDS complexity. In the NPRM, CMS proposes to modify MDS items, particularly fully-specified diagnosis coding for multiple conditions, procedures, and comorbidities, which greatly complicate MDS completion. Such additions will create new challenges associated with securing supporting documentation to ensure timely payment. Additionally, the role of the MDS Coordinator will change substantially and will require a higher level of skills associated with process management. We believe these changes create significant new compliance risks and new program integrity issues for CMS. ***Recommendation:*** *We offer solutions to these issues in Subsection G Attachment A. Additionally, CMS should review its assessment-related regulation at 42 C.F.R. 483.20(j)(2), which states that "[c]linical disagreement does not constitute a material and false statement," relative to its PDPM proposal.*

- *Use of 5-Day Assessment and Securing Clinician Sign-Off Creates Timing Challenges.* The initial 5-Day PPS Assessment is used to classify a patient and establish per-diem payment for the entirety of the SNF stay. Securing clinician sign off and all needed medical information for multiple fully-specified ICD-10 diagnosis codes on the MDS in time for a 5-day assessment will be very challenging and virtually impossible for procedure codes. Furthermore, such detailed coding often requires the results of specific lab and test results not performed by or readily available to SNFs at the point of admission. For example, hospitals often discharge patients to SNFs on Friday evenings when clinical professionals are extremely difficult to reach. ***Recommendation:*** *AHCA proposes two ideas to address this challenge. See Subsection F and Subsection G Attachment A for more detail.*

- *Prescription drug data from the NTAS component could be inconsistent with diagnosis coding.* During the transition and initial implementation period, many SNFs may code a patient in one way using ICD-10-CM on the 5-day MDS for purposes of admission, but NTAS comorbidities and extensive services for the same patient do not align with the claim ICD-10-CM code(s). ***Recommendation:*** *Again, such level of detail to accurately report NTA comorbidities is excessive and creates unnecessary compliance risk and new CMS burden. However, our proposed alternative to use of ICD-10 codes on the MDS for NTAS discussed in Section 3 Subsection E. would address this challenge.*

- *Proposed MDS Section O Therapy Reporting Items on the Discharge MDS must match claims.* CMS has proposed to require SNFs to report therapy use in the MDS Section O items. These Section O items would be redundant and would need to match the claim therapy reporting to cross-check service delivery and mitigate audit risk. ***Recommendation:*** *AHCA believes therapy minute tracking*

should only be required on claims to address this potential risk. Claims would be subject to audit and could be linked back to the clinical record (See Section 3, Subsection H.

- *Interrupted Stay Policy Transitions*. For interrupted stays of greater than three days or in SNF-to-SNF transfers, a new five-day assessment would be required. Similar issues arise in these transitions with consistency of coding and alignment of coding among settings. Additionally, CMS notes that "we plan to monitor the use of [the interrupted stay] policy closely to identify those facilities whose beneficiaries experience frequent readmission, particularly facilities where the readmissions occur just outside the three-day window used as part of the proposed interrupted stay policy. Should we discover such behavior, we will flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking." However, CMS has not aligned the planned monitoring with existing quality measures, and instead has created an incentive for such provider behavior by prohibiting providers from returning patients to days one through three for typically high cost non-therapy ancillary services (NTAS) when an IPA is conducted or in the instance of interrupted stays of three or less days. ***Recommendation:*** *AHCA has developed two possible alterations to CMS' proposed admission MDS and Interim Payment Assessments that will address these challenges (see Section 3, Subsection G).*

- *CMS' proposed IPA creates significant new compliance risk.* Due to IPA policies and likely PDPM provider behavioral changes, SNFs are at risk in the following scenarios: 1) with lengths of stay expected to go down, shorter lengths of stay would increase the risk of residents being discharged before an IPA completion error could be detected and corrected; and 2), as noted above, SNFs will be subject to significant second guessing by RACs and others in regard to whether IPAs should have been performed but were not. ***Recommendation:*** *AHCA has offered an array of IPA solutions in Section 3, Subsection G. However, we believe this issue is complex and significant enough to merit a Technical Expert Panel.*

Additionally, we are unclear on an array of code-related issues with profound financial implications for SNFs:

- AHCA would like to understand how CMS will track and reconcile admission diagnosis and component classifications, any IPAs and the final discharge assessment information (e.g., diagnosis, "condition of the patient," classification) and payment. We envision tens of thousands of classification iterations. By the nature of increased payment classifications, error rates would likely increase, particularly without substantial training and software developed with CMS specifications to ensure coding aligns with payment system design specifications. Furthermore, we envision substantial increases in the number of stays, shorter in length but which must be reconciled. This will create compliance risks for providers that are attempting to ensure that Medicare stays are properly billed.

- The Association also is unclear on CMS processes to reconcile hospital ICD-10 codes with SNF claim and MDS ICD-10 codes. Incongruent coding could result in RAC and other review contractor recovery going back two to three years.

- AHCA also is concerned about subsequent adjustments could lead to provider refund obligations under the 60-day Overpayment Rule. This also would create enhanced administrative burden for MACs and providers alike.

Recommendation: *AHCA requests that the Center for Medicare, Chronic Care Policy Group, and the Center for Program Integrity provide guidance on how these issues will be addressed in a manner that does not place providers at risk of alleged improper billing and recovery years after patient stays viewed as problematic.*

Finally, CMS would continue to hold SNFs to the highest practicable standard. However, because of resource use measures in hospital and physician value-based purchasing programs and efficiency imperatives built into bundling and Accountable Care Organization models, SNFs would be under substantial pressure to discharge patients as quickly as possible to keep costs down. ***Recommendation***: *CMS should clarify how the Agency has considered the combined interaction of these various Medicare payment system pressures and new PDPM payment system on other SNF programs, such as the IMPACT Act QRP, as well as various other SNF programs (See Attachment A) in light of its Patients Over Paperwork Initiative.*

In sum, we respectfully request that CMS discuss its plans to address these new compliance challenges for providers and program integrity challenges for the Agency.

Attachment A
SNF Burden and Patients Over Paperwork Illustration

Current and Future Changes	Key Highlights
Focused Surveys	
MDS Focused Surveys	• Focus on MDS accuracy and frequency ○ Posting and archiving of daily staffing
Dementia Focused Surveys	• Staff training and demonstrated competency in dementia care
Adverse events focused on surveys	• Focus on medication errors • How SNFs investigate adverse event
Requirements of Participation	• Proposes extensive changes estimated by CMS to cost the SNF profession an additional $684 million-plus in annual operating expenses
New Life Safety Codes	• Updates Life Safety Codes to national 2012 life safety codes • Increases inspection, testing, and maintenance requirements • Additional sprinkler system requirements
New Emergency Preparedness Requirements for all Provider Types	Extensive rewrite with all hazard approach; with cost implications to comply, need to have: • Plan and tested plan for different types of emergencies and must meet the needs of the type of residents served • Test generator on load 1x year for 4 hours • Training upon hire and annually
Discharge Planning for Hospitals and Home Health	Proposed Rule issued November 2016; impacts SNFs: • Requires hospitals to give patients info on SNF quality prior to discharge and advice on SNF selection • SNFs in managed care network
OSHA Electronic Reporting of Illnesses and Injuries	• Database of electronic reporting info will be made available to public
Department of Labor Rules on exempt and non-exempt employment	Defining and Delimiting the exemption for executive, administrative, professional, outside sales, and computer employees (RIN 1235-AA11) with key proposed changes: • Setting minimum salary levels and hourly rates and overtime requirements and annual inflator; and • Changes criteria about exempt compensated employees
States	
State and Municipal Minimum Wage Laws	Approximately a dozen states have enacted or are developing minimum wage laws, as well as an array of municipalities

Current and Future Changes	Key Highlights
Quality Measure & Reporting	
IMPACT Act	Changes to MDS – 2016 SNF PPS rule added new section GG to MDS and changes to MDS discharge assessments. Need to complete when discharged from Part A coverage. Three finalized measures and four proposed.
Changes to Five Star	• Added new measures – rehospitalization, discharge to community, mobility in room, change in ADL from admission
Payroll Based Journal	• Requires quarterly submission of staffing from payroll and all contract and agency use collected and reported by employee name
Payment to SNFs	
SNF VBP	• 2% withhold linked to rehospitalizations
IMPACT Act Failure to Report Penalty	Beginning in 2016 for the three finalized, IMPACT Act measures, SNFs that fail to report on quality measures, will be subject to a 2 percentage point reduction in market basket prices in effect under the existing payment methodology in the Social Security Act. • Also will require fundamental changes in SNF operations focusing on quality outcomes.
Alternative Payment Methods	
CMMI demonstrations including BPCI, CJR, and ACOs	• These demonstrations include extensive work on condition categories and patient characteristics. All of this could be leveraged to enhance the RCS project • Bundling target pricing and ACO efficiency measurement both would have to be adjusted to account for the new payment system
Medicare Advantage (MA)	
Most MA plans pay using some form of RUG IV	• A strategy to transition plans to any new SNF payment system would be needed • Without such an approach, providers and plans would have to run parallel payment systems. For example, most plans pay out-of-network providers using fee-for-service rates. If new system is implemented without sufficient education and transition multiple payment systems would persist and it is highly unlikely that providers will ever realize the CMS estimated $2 billion in savings over ten years

Subsection D. Beneficiary Protections

CMS Request for Comment	AHCA Comments In-Brief
Page 21037 – We invite comments on any and all aspects of the proposed PDPM, including the research analyses described in this proposed rule, the SNF PDPM technical report.	• In terms of projected long-stay residents and patients with other clinical needs who may require skilled maintenance therapy, we remain concerned CMS' proposed therapy components and minutes counting proposal does not adequately account for the ***Jimmo*** settlement defined skilled maintenance therapy. • Above, we note the Requirements for Participation Comprehensive Person-Centered Plan provision were not mentioned in the NPRM and we believe CMS' projected per building savings from MDS reductions and OMRA elimination do not support this requirement. • As we have noted in other sections, we believe that tapering with no special provisions for specific types of patients will create access problems. We offer a solution in Section 3 Subsection F,1.b I. • Already patients struggle with the grievances and appeals process. We request clarification on how patients will be educated on how to appeal classification or reclassifications among five distinct service components and related IPA implications. • As with RCS, PDPM incentivizes shorter lengths of stay. AHCA supports efforts that create Medicare programmatic efficiencies, but not when they create new risks for beneficiaries. Also, in Section 3 Subsection G.1.a we discuss an alternative IPA approach which might address this issue at least in FFS. • AHCA also recommends an educational effort with the Administration on Aging, Long-Term Care Ombudsman Office on the new payment system and its implications for skilled nursing.

General Position Statement

AHCA believes a critical aspect of any payment system is consideration of beneficiary protections. PDPM, based upon patient characteristics, is intended to be patient driven. However, we note an array of points CMS should address to ensure the system truly is patient-driven rather than solely driven by Medicare payment efficiency.

1. ***Jimmo*** *and Maintenance Therapy*

During the Technical Expert Panels in June and October 2016, participants repeatedly raised concerns with CMS' contractor regarding how the ***Jimmo*** settlement was accounted for in the payment system. CMS' contractor indicated follow-up would be necessary and that additional material would be forthcoming. To-date, no additional information has been shared. AHCA requests clarification on how Jimmo is accounted for in the new system, particularly for residents who will likely require skilled

maintenance therapy through the end of the benefit period. For example, in the discharge assessment description, CMS notes a proposed requirement for therapy minutes reporting. The Association would like to understand whether reported therapy minutes will be broken out in reporting as maintenance versus restorative or whether CMS has developed other methods of assuring access, and for collecting information on delivery of skilled maintenance therapy. The example of Section O MDS items found on page 21065, Table 35, includes no discussion regarding how maintenance therapy will be accounted for on MDS or on claims. ***Recommendation:*** *We request clarification on tracking maintenance therapy if Section O is used. We also propose an alternative claims-based therapy tracking mechanism in Section 3 Subsection H that includes a solution of tracking maintenance therapy.*

2. Requirements of Participation Comprehensive Person-Centered Plan

As noted above, Section 483.21 of the Requirements for Participation requires development of Comprehensive Person-Centered Care Plan. The PDPM proposal creates new, more specific criteria among a more granular array of service components based upon medical documentation. And CMS asserts that reduced patient MDS assessments will produce administrative savings for SNFs. ***Recommendation:*** *The Association requests clarification regarding how a patient's voice will be heard in a Comprehensive Care Planning process in which care design will be driven by medical information. We also request clarification on how Comprehensive Person-Centered Plan maintenance services will be factored into CMS' estimated savings of $12,000 per building per month and how such plans will be supported by the proposed changes.*

3. Special Populations and Access Issues

AHCA also has continuing concerns related to potential unintended PDPM consequences for certain beneficiary populations. Such unintended consequences may include reduced access to services and/or greater out-of-pocket costs as a percentage of Medicare's payment to providers. In particular we are concerned about beneficiaries whose diagnosis and/or condition creates a certainty that a full 100-day benefit period with daily skilled services will be utilized. In such cases, the tapering effects of the variable payment rate adjustments for the PT, OT, and particularly NTA rate components may erode payment to the point where average payment for the stay is below the actual direct cost of providing the services. This scenario may result in access issues for patients with specific diagnoses/conditions for whom high-cost medications and/or daily use of costly medical equipment does not taper over time, and for whom therapy services maintain or slow down the progression of degenerative chronic conditions. ***Recommendation:*** *CMS should study and provide a detailed report on the characteristics of beneficiaries in a PDPM simulation period who had SNF stays that exceeded 90 days in length to determine whether it creates potential access issues for such beneficiaries. AHCA also requests comment regarding whether CMS should consider creating a "tapering waiver" for NTAS tapering to mitigate access issues for such patients. Additionally, in Section 3 Subsection F,1.b we offer an alternative to the proposed IPA structure that could aid with this issue.*

4. Shorter Lengths of Stay Incentivized

Tapering payments will incentivize shorter lengths of stay. In no way does AHCA imply inappropriate provider behavior will occur, but we see the potential for unintended outcomes for beneficiaries. ***Comment:*** *The Association requests CMS discuss how such possible issues will be monitored, identified, and addressed.*

Subsection E. Component-by-Component Comments

CMS has long had an overarching goal to reduce fragmentation in payment and health care delivery. And, we appreciate the reduction in the number of component case mix groups.

The Association remains concerned about initial component classification and the mechanism for changing component case mix groups, the Interim Payment Assessment. In Section G, we offer recommended solutions to address these challenges.

Below, in Table 1, we provide a summary of component-specific recommendations. Following the table are detailed comments on each proposed component.

Table 1. Overview of Component by Component AHCA Comments

CMS Request for Comment	AHCA Comments In-Brief

Page 21049 – We invite comments on the approach we are proposing above to classify residents for PT and OT payment.	• AHCA does not support the proposed PDPM ICD-10 diagnosis approach to reporting information on the MDS.
	  ○ AHCA agrees in concept with the suggested alternative of using an MDS checklist item-set approach to determine PT and OT clinical categories under PDPM, but recommends a revised version that does not utilize the MDS section I0020 checklist
	• AHCA supports the revised CMS approach to propose using MDS section GG items rather than section G items to represent resident function at admission for PT and OT component case-mix adjustment purposes.
	• AHCA has identified a flaw in the proposed PT and OT component function score case-mix adjustor related to the use of a MDS item GG0170H1 that is being retired on September 30, 2018.
	  ○ AHCA proposes an alternative solution to replace the MDS item being retired.
	• AHCA recommends that CMS formalize a transparent process and timeline to refine the PT and OT component case-mix determination approach soon after the implementation of PDPM, if adopted, to assess whether the following factors would influence the ability of the model to better predict PT and OT resource use including:
	  ○ New MDS section GG items addressing a broader range of mobility and self-care activities that are being introduced October 2018,
	  ○ New MDS section GG items addressing prior level of function performing everyday

CMS Request for Comment	AHCA Comments In-Brief
	activities including; self-care ADLs, indoor mobility (walking), negotiating stairs, and functional cognition that are being introduced October 2018, ○ Indicators of current cognitive impairment including those being developed under the SNF QRP, and ○ Potential comorbidities related to PT and OT utilization as discussed in pages 40-45 of the PDPM Technical Report.
Page 21051 – We invite comments on the approach we are proposing above to classify residents for SLP payment under the proposed PDPM.	• AHCA does not support the proposed PDPM ICD-10 diagnosis approach to reporting information on the MDS. ○ AHCA agrees in concept with the suggested alternative of using an MDS checklist item-set approach to determine SLP clinical categories under PDPM, but recommends a revised version that does not utilize the MDS section I0020 checklist • AHCA does not support the proposed PDPM approach to apply the same PDPM condition code as the first step in determining the PT, OT, and SLP case mix. ○ AHCA recommends an alternative approach to identify the PDPM condition code that most applies to the reason for SLP to protect beneficiary access in cases where the resident presents with multiple conditions. • AHCA does not support the proposed PDPM ICD-10 diagnosis approach to reporting SLP comorbidity items on the MDS to determine the SLP case-mix. ○ AHCA recommends an alternative approach to add the newly identified SLP comorbidity items to an existing MDS checklist item set to determine the SLP case-mix under PDPM. • AHCA recommends that CMS formalize a transparent process and timeline to refine the SLP component case-mix determination approach soon after the implementation of PDPM.
Page 21055 – We invite comments on the approach we are proposing above to classify	• Due to the lack of available data, AHCA has struggled with development of solutions for CMS.

CMS Request for Comment	AHCA Comments In-Brief

residents for nursing payment under the proposed PDPM.	And, we remain concerned about the data sources upon which CMS had relied.
	• In the discussion below, the Association discusses in detail our rationale for believing the nursing component has historically been, and continues to be, underfunded.
	• Short-Term Solutions – Allow for More Expeditious Nursing Case Mix Group Changes
	  ○ Initial/Admission Assessment – Build off the Current RAI Modification Provision to allow for case mix group adjustment as expeditiously as possible without the need for an IPA.
	  ○ Lengthen the Initial Assessment window from five to eight days to an outer limit of 14 days to allow more time for hospital information to become available.
	• Long-Term Solution – Because of the critical nature of nursing and the paucity of data, AHCA urges CMS to consider the Association's research on modern clinical practice and be prepare for early recalibration of the nursing component.

Page 21059 – We invite comments on the approach proposed above to classify residents for NTA payment under the proposed PDPM.	• Initial Admission Assessment – Build on the Current RAI Modification Provision to Allow for Adjustments without an IPA
	• Develop a clear, definitive, clinically-driven threshold for resetting NTA tapering
	• Create a NTAS Default Category
	• Clarify:
	  ○ Changes on Conditions and Services List from RCS-1 List
	  ○ Low Point Assignments for High Cost and Ongoing Conditions and/or Service Needs
	• AHCA does not support the proposed PDPM ICD-10 diagnosis approach to reporting NTA condition items on the MDS to determine the NTA case-mix.
	  ○ AHCA recommends an alternative approach to add the newly identified NTA Condition items to an existing MDS checklist item set to determine the NTA case-mix under PDPM.

i. Physical Therapy/Occupational Therapy

NPRM Comment Request	AHCA Comments
Page 21042-21049 –. We invite comments on the approach we are proposing above to classify residents for PT and OT payment.	- AHCA does not support the proposed PDPM ICD-10 diagnosis approach to reporting information on the MDS o AHCA agrees in concept with the suggested alternative of using an MDS checklist item-set approach to determine PT and OT clinical categories under PDPM, but recommends a revised version that does not utilize the MDS section I0020 checklist
	- AHCA supports the revised CMS approach to propose using MDS section GG items rather than section G items to represent resident function at admission for PT and OT component case-mix adjustment purposes
	- AHCA has identified a flaw in the proposed PT and OT component function score case-mix adjustor related to the use of a MDS item GG0170H1 that is being retired on September 30, 2018 o AHCA proposes an alternative solution to replace the MDS item being retired
	- AHCA recommends CMS formalize a transparent process and timeline to refine the PT and OT component case-mix determination approach soon after the implementation of PDPM, if adopted, to assess whether the following factors would influence the ability of the model to better predict PT and OT resource use, including: o New MDS section GG items addressing a broader range of mobility and self-care activities that are being introduced October 2018 o New MDS section GG items addressing prior level of function performing everyday activities including; self-care ADLs, indoor mobility (walking), negotiating stairs, and functional cognition that are being introduced October 2018 o Indicators of current cognitive impairment including those being developed under the SNF QRP o Potential comorbidities related to PT and OT utilization as discussed in pages 40-45 of the PDPM Technical Report

General Position Statement

AHCA views the separation of the PT and OT components and the consolidation of 30 case mix groups to 16, as well as the proposed use of MDS Section GG mobility and self-care items, and the consideration of using a condition checklist in the MDS instead of fully defined ICD-10-CM and -PCS codes as positive. However, we do not believe MDS

item I0020 is an acceptable solution. Below we offer detailed comments related to the proposed PT and OT component design and our recommended alternative solutions.

1. CMS Proposal

CMS is proposing to create three separate therapy case-mix adjusted components (PT, OT, and SLP) in the PDPM payment system to replace the current RUG-IV model that combines the three disciplines into a per-diem rate component. This section of the NPRM discusses the construction of the proposed PT and OT components of PDPM. Section V.D.3.c. of the NPRM (see Subsection E, ii, Speech Language Pathology) discusses the construction of the SLP component. Under the proposed PDPM model, the separate PT and OT components will be similar in several ways, differing only in how the CMI weights are assigned.

a. PT and OT Clinical Categories

CMS proposes to use 10 different clinical reason for stay categories (see NPRM Table 14) that are compressed into four PT and OT clinical categories based on similar per-diem PT or OT costs (see NPRM Table 15). The first line in item I8000 would be used to report the ICD-10-CM code that represents the primary reason for the resident's Part A SNF stay. The second line of item I8000 would be used to report an ICD-10-PCS code that corresponds to the type of surgical procedure performed during the prior inpatient stay (if applicable). CMS invited comments on their proposal to categorize a resident into a PDPM clinical category using the ICD-10-CM code recorded in the first line of item I8000 on the MDS 3.0, and the ICD-10-PCS code recorded on the second line of item I8000 on the MDS 3.0. In addition, CMS is soliciting comments on an alternative solution they presented of using I0020 checklist items on the MDS 3.0 as the basis for resident classification into one of the 10 clinical categories in Table 14.

b. PT and OT Component Payment Adjustors

CMS described the rationale for proposing to use resident function as a payment adjustor for the PT and OT payment components, and why the approach was modified from the previous RCS-1 model discussed in last year's ANPRM. Specifically, using MDS Section G items for function and other items for cognitive status conceptualized in the prior RCS-1 approach would be replaced with using functional items from section GG of the MDS 3.0 (Functional Abilities and Goals) as the basis for calculating the function score for resident classification used under PDPM. Cognitive status would not be used to adjust PT and OT case-mix rates under PDPM as proposed.

Under PDPM, a resident's function would be measured using four late-loss ADL activities (bed mobility, transfer, eating, and toileting) and two early-loss ADL activities (oral hygiene and walking). The proposed functional score includes: two bed mobility items, three transfer items, one eating item, one toileting item, one oral hygiene item, and two walking items that were all found to be highly predictive of PT and OT costs per day. The list of proposed section GG items that would be included in the functional measure for the PT and OT components is shown in NPRM Table 18. These represent available

Section GG items introduced in October 2016 that demonstrated favorable predictive power.

Under PDPM, each of these ADL areas would be assigned a score of up to four points (see NPRM Tables 16 and 17). CMS describes that unlike MDS Section G items, section GG includes multiple items addressing similar functional areas, but with more precision and predictive ability than Section G items. To adjust for this overlap, CMS proposes to calculate an average score for these related items. That is, CMS would average the scores for the two bed mobility items, the three transfer items, and the two walking items rounding to the nearest integer within each functional area (see NPRM Table 18). This proposed scoring algorithm produces a function score that ranges from 0 to 24 under PDPM. CMS invites comment on the proposed approach to use Section GG functional items as the only payment adjustors within the PT and OT components under PDPM.

c. PT and OT PDPM Case-Mix Groups

CMS is proposing that the same 16 case-mix groups be used to classify residents for PT and OT PDPM payment. Specifically, as described above, residents will first be assigned to the four compressed PT and OT clinical categories; Major Joint Replacement or Spinal Surgery, Other Orthopedic, Medical Management, and Non-Orthopedic Surgery and Acute Neurologic (NPRM Table 15). Then, the only case-mix adjustment factor that will be applied will be four functional score tiers (NPRM Tables 16-18, and 21). The PDPM PT and OT CMI weights will be determined independently based on cost report and utilization data (see NPRM Table 21). It is notable that the PT weights are higher for the orthopedic groups and OT weights are higher for the non-orthopedic groups. CMS invited comment on this proposed approach.

2. AHCA Comments

AHCA appreciates that CMS has responded to critique of the previous RCS-1 SNF payment redesign model by conducting additional analysis and revising the design of the PT and OT component. While the design of the model appears to be moving in a positive direction, we believe CMS would need to further address three specific areas before we could support the proposed PDPM PT and OT component design. First, CMS must simplify the process for identifying and reporting the 10 PDPM clinical categories used to create the four collapsed PT and OT clinical categories. Second, CMS must address a flaw in the proposed MDS section GG items needed for PDPM function score construction. Finally, CMS must establish a specific and transparent process and timeline to refine the PDPM PT and OT component case-mix model soon after implementation using newly available and real SNF data, rather than the simulated hospital diagnostic data used in case-mix modeling. The following comments further detail these three specific areas.

a. Determination of PDPM Clinical Categories Used to Identify PT OT Collapsed Clinical Categories

The proposed CMS design of the PDPM had compressed the extensive list of over 65,000 available ICD-10-CM codes, of which 40,924 fully-specified codes are mapped to the PDPM model into a relatively small and reasonable list of discrete clinical groupings that apply to the PT, OT, and SLP components.

Feedback from AHCA front-line clinical experts indicate they are extremely concerned that the proposed approach to require entering specific ICD-10-CM and possibly ICD-10-PCS codes is excessively burdensome and unnecessary to report the resident's primary condition necessary for determining the PT and OT component case mix weights during the limited admission assessment period. We note that fully-described coding often includes details of anatomical structures, test results, and procedures furnished in an inpatient hospital basis that are not readily available to the SNF, and many (24,114) are identified as return-to-provider (RTP) codes not mapped to PDPM that could create billing and compliance problems if used. We believe reporting the descriptive PDPM clinical category that applies to the resident upon admission, rather than fully-specified ICD-10-CM or ICD-10-PCS codes, best furthers CMS' goal of reducing provider burden and better facilitates the ability of the SNF to accurately identify an appropriate PDPM clinical category from available documentation.

Proposed Solutions:

- **We are proposing that CMS design the PDPM model so the provider has the option to enter all required patient PDPM PT, OT, and SLP component clinical category classification information on the MDS via descriptive checklist, rather than fully-specified ICD-10-CM or ICD-10-PCS codes.**

Regardless of the reporting method, the medical record documentation supporting how the MDS items were reported are the same. However, the checklist option reduces significant administrative and compliance burdens associated with identifying and justifying fully-described ICD-10-CM or ICD-10-PCS while having no impact on payment accuracy.

Specifically, as an alternative option to submitting ICD-10-CM and ICD-10-PCS codes as proposed in the NPRM, CMS would add checklist items to Section I of the SNF PPS admission MDS for providers to report the primary condition for PT, OT, and SLP component classification. This recommendation would not preclude providers from entering ICD-10-CM codes into Section I8000 of the MDS that map to any of the PT or OT conditions (as CMS has proposed) if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently. This recommendation would not change existing ICD-10-CM principal claim diagnosis reporting requirements that are subject to the submission of fully-specified ICD-10-CM

codes per MAC claims-processing and Local Coverage Determination (LCD) coding policies.

While we appreciate the CMS offer in proposing the use of Section I0020 of the MDS for such a purpose, we believe it would be inappropriate to do so as described. The current I0020 item set was established specifically for the SNF QRP mobility and self-care outcomes measures to be implemented on October 1, 2018. We believe the existing I0020 item set is insufficient for determination of the PDPM clinical categories proposed to be used for the PT, OT, and SLP PDPM clinical categories, and any modifications to this item set would corrupt the SNF QRP mobility and self-care outcome measures.

Instead, the specific descriptive condition checklist items AHCA recommends being added to Section I of the MDS (e.g. a new section I8030 labeled *"Indicate the resident's primary PDPM clinical category"*) to represent the PT, OT, and SLP primary PDPM Clinical Category consistent with the NPRM and the PDPM Calculation Worksheet pages 5, 9, and 13 are:

- 01 - Major Joint Replacement or Spinal Surgery
- 02 - Non-Orthopedic Surgery
- 03 - Acute Neurologic
- 04 - Non-Surgical Orthopedic/Musculoskeletal
- 05 - Orthopedic Surgery (Except Major Joint Other Orthopedic Replacement or Spinal Surgery)
- 06 - Acute Infections
- 07 - Cancer
- 08 - Pulmonary
- 09 - Cardiovascular and Coagulations
- 10 - Other Medical Management

***

- **We propose that the MDS manual guidance could describe the clinical documentations that would support whether one of these condition items are checked as present, similar to how other existing MDS items are defined in the MDS manual**

Please see Section 3 Subsection G Attachment A of these comments for an example of MDS Manual guidance for our Proposed Definition of PDPM 10 Primary Clinical Categories.

In summary, The AHCA proposal would provide an option to remove much of the complexity and burden associated with identifying and mapping tens of thousands of diagnosis codes that could apply to the PDPM PT and OT case-mix weights during the brief admission assessment window. Additionally, the extensive collapsing of the PT and OT conditions into only four discrete primary level case-mix groupings significantly

minimizes the risks of classification of the resident into the wrong tier one payment classification group.

b. Flaw in the Proposed MDS Section GG Items Needed for PDPM Function Score Construction

We believe the NPRM Table 17 footnote reflects a flaw in the PDPM design of the function score construction design. Specifically, it references MDS item GG0170H1 (Does the resident walk?) which is being retired September 30, 2018, with the introduction of the newer, more detailed SNF QRP mobility and self-care outcome measure items. We also note that on pages 5-6 of the *PDPM Calculation Worksheet for SNFs*, CMS provides the following instruction using this soon-to-be-retired MDS item:

> *"Determine if the resident can walk using item GG0170H1. If the resident cannot walk GG0170H1=0 or 1), then the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) is 0. If the resident can walk (GG0170H1=2), then determine the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) using the following table."*

Admission Performance (Column 1) =	Function Score =
05, 06	4
04	3
03	2
02	1
01, 07, 09, 88	0

Proposed Solution:

- **As a solution to this flaw, we recommend that CMS adopt MDS item GG0170I (Walk 10 feet) as a substitute for retired item GG0170H1.**

We do not recommend that CMS restore MDS item GG0170H1 to the MDS as we believe the new section GG item GG0170I being introduced in October 2018 would be an acceptable option, and that restoring a retired item would add unnecessary administrative burden when an appropriate substitute item was available. We note that although a resident could conceivably be able to walk a short distance under the new MDS item, the inability to walk at least 10 feet with more than substantial/maximal assistance suggests a significant mobility impairment that is essentially equivalent to the definition of the retired "cannot walk" MDS item. If our recommendation is adopted, we recommend the following alternative guidance to correct the flaw on pages 5-6 of the *PDPM Calculation Worksheet for SNFs* described above.

"Determine if the resident can walk 10 feet using item GG0170I. If the resident cannot walk 10 feet or is completely dependent on others GG0170I=01, 07, 09, 10, or 88), then the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) is 0. If the resident can walk 10 feet with substantial/maximal assistance or less (GG0170I=02, 03, 04, 05, or 06), then determine the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) using the following table."

c. *Transparent Process and Timeline for PDPM PT and OT Component Refinement*

We have stated throughout the CMS process of developing the SNF PPS payment redesign model, currently referred to as PDPM in this NPRM, our concerns that the model is based upon a foundation of using inpatient hospital diagnosis, other non-SNF data, and limited available MDS data as a proxy for new MDS items to be introduced and used to determine the PT and OT primary clinical categories that serve as the foundation for the respective case-mix groupings. This foundation has resulted in a design where only function is currently proposed as a case-mix adjuster beyond clinical group for both the PT and OT components. Other variables and comorbidities that did not meet the threshold for inclusion in the current PDPM model may become important once SNF-generated MDS data is available after implementation.

Proposed Solution:

- AHCA recommends that CMS formalize a transparent process and timeline to refine the PT and OT component case-mix determination approach soon after the implementation of PDPM, if adopted, to assess whether the following factors would influence the ability of the model to better predict PT and OT resource use including:

  a. New MDS section GG items addressing a broader range of mobility and self-care activities that are being introduced October 2018
  b. New MDS section GG items addressing prior level of function performing everyday activities, including self-care ADLs, indoor mobility (walking), negotiating stairs, and functional cognition that are being introduced October 2018
  c. Indicators of current cognitive impairment including those being developed under the SNF QRP
  d. Potential comorbidities related to PT and OT utilization as discussed in pages 40-45 of the PDPM Technical Report

ii. Speech-Language Pathology

NPRM Comment Request	AHCA Comments
Page 21049-21051 –. CMS is inviting comments on the approach they are proposing above to classify residents for SLP payment under the proposed PDPM.	• AHCA does not support the proposed PDPM ICD-10 diagnosis approach to reporting information on the MDS. o AHCA agrees in concept with the suggested alternative of using an MDS checklist item-set approach to determine SLP clinical categories under PDPM, but recommends a revised version that does not utilize the MDS section I0020 checklist
	• AHCA does not support the proposed PDPM approach to apply the same PDPM condition code as the first step in determining the PT, OT, and SLP case mix o AHCA recommends an alternative "index-maximizer" approach to identify the PDPM condition code that most applies to the reason for SLP to protect beneficiary access in cases where the resident presents with multiple conditions
	• AHCA does not support the proposed PDPM ICD-10 diagnosis approach to reporting SLP comorbidity items on the MDS to determine the SLP case-mix o AHCA recommends an alternative approach to add the newly identified SLP comorbidity items to an existing MDS checklist item set to determine the SLP case-mix under PDPM
	• AHCA recommends that CMS formalize a transparent process and timeline to refine the SLP component case-mix determination approach soon after the implementation of PDPM

General Position Statement

AHCA views the consolidation of 16 case mix groups to 12, as well as the proposed use expanded SLP case-mix adjustment factors, and the consideration of using a condition checklist in the MDS instead of fully defined ICD-10-CM codes as positive. However, we do not believe that MDS item I0020 is an acceptable solution, nor do we believe it is appropriate for the SLP component to use the same condition identifier as PT and OT if SLP is being furnished for a different condition. Below we offer detailed comments related to the proposed SLP component design and our recommended alternative solutions.

1. *CMS Proposal*

CMS is proposing to create three separate therapy case-mix adjusted components (PT, OT, and SLP) in the PDPM payment system to replace the current RUG-IV model that combines the three disciplines into a per-diem rate component. The prior section of the NPRM discusses the construction of the proposed PT and OT components of PDPM.

This section of the NPRM discusses the construction of the SLP component. Under the proposed PDPM model, the separate SLP component construction will be markedly different than the PT and OT components. On page 21049 of the NPRM, CMS offers the following rationale:

> *"…many of the resident characteristics that we found to be predictive of increased PT and OT costs were predictive of lower SLP costs. As a result of this inverse relationship, using the same set of predictors to case-mix adjust all three therapy components would obscure important differences in variables predicting variation in costs across therapy disciplines and make any model that attempts to predict total therapy costs inherently less accurate. Therefore, we believe it is appropriate to have a separately adjusted case-mix SLP component that is specifically designed to predict relative differences in SLP costs.*

As a result, CMS is proposing a methodology to determine the SLP case-mix component that will use three categories of predictors substantially different than those for the proposed PT and OT components using the following approach:

1. To determine the initial resident classification into an SLP group under the proposed PDPM, residents would first be categorized into one of two groups using the clinical reasons for the resident's SNF stay recorded on the first line of Item I8000 on the MDS assessment: either the "Acute Neurologic" clinical category or a "Non-Neurologic" group that includes the remaining clinical categories in Table 14 (See PT and OT component comments above for Table 14 discussion).
2. Residents will be identified for the presence of swallowing disorders and/or mechanically altered diet and/or both or neither as follows:
    a. Residents who exhibit the signs and symptoms of a swallowing disorder, will be identified using item K0100Z on the MDS 3.0
    b. The presence of a mechanically-altered diet will be determined by item K0510C2 on the MDS 3.0
3. Residents will be identified by cognitive status and the presence of an SLP-related comorbidity as follows:
    a. Residents with a mild to severe cognitive impairment (as defined by the PDPM cognitive measure methodology described in Table 20 – See PT and OT component comments above for Table 20 discussion)
        i. CMS proposes a slightly modified MDS-item-driven *Proposed PDPM Cognitive Measure Classification Methodology* scale than the Cognitive Function Scale (CFS) proposed with RCS-1 so some residents unable to complete BIMS could still be identified as "cognitively intact"
    b. Residents with the presence of at least one SLP-related comorbidity among the conditions listed in Table 22 (See PT and OT component comments above for Table 22 discussion)

CMS is proposing 12 case-mix groups to classify residents for SLP payment (NPRM Table 23). This will be achieved by: 1) Combining the clinical category (Acute Neurologic or Non-Neurologic), cognitive impairment, and the presence of an SLP-related comorbidity into a single predictor due to the clinical relationship between acute neurologic conditions, cognition, and SLP comorbidities; and 2) Applying the presence of a swallowing disorder or mechanically-altered diet as the second predictor variable. CMS is proposing the SLP component per-diem rate will not vary during the stay based on analysis that per-diem intensity of SLP services remained relatively consistent through stays of any duration.

CMS is inviting comments on the approach they are proposing above to classify residents for SLP payment under the proposed PDPM.

2. AHCA Comments

AHCA appreciates that CMS has responded to critique of the previous RCS-1 SNF payment redesign model by conducting additional analysis and revising the design of the SLP component. While the design of the model appears to be moving in a positive direction, we believe CMS would need to further address the following specific areas before we could support the proposed PDPM SLP component design. First, CMS must simplify the process for identifying and reporting the conditions and comorbidities used to create the SLP clinical categories. Second, CMS must use the clinical reason for the SNF stay that applies to SLP service needs rather than the same code used to determine the PT and OT case-mix. Finally, CMS must establish a specific and transparent process and timeline to refine the PDPM SLP component case-mix model soon after implementation using newly-available and real SNF data, rather than the simulated hospital diagnostic data used in case-mix modeling. The following comments further detail these specific areas.

i. Determination of PDPM Clinical Categories Used to Identify the SLP Clinical Categories

The proposed CMS design of the PDPM had compressed the extensive list of over 65,000 available ICD-10-CM codes, of which 40,924 fully-specified codes are mapped to the PDPM model into a relatively small and reasonable list of discrete clinical groupings that apply to the PT, OT, and SLP components. Feedback from AHCA front-line clinical experts indicate they are extremely concerned that the proposed approach to require entering specific ICD-10-CM and possibly ICD-10-PCS codes is excessively burdensome and potentially unnecessary to report the resident's primary condition necessary for determining the SLP component case mix weights during the limited admission assessment period.

Proposed Solution:

- **We propose that CMS design the PDPM model so the provider has the option to enter all required patient PDPM PT, OT, and SLP component clinical category**

classification information on the MDS via descriptive checklist, rather than fully-specified ICD-10-CM or ICD-10-PCS codes.

Please refer to our detailed NPRM Section V.D.3.b. *Proposed Physical and Occupational Therapy Case-Mix Classification* comments above for further discussion of our concerns and details of our recommended solution that would apply to all three therapy disciplines.

ii. Linkage of the PT, OT, and SLP Component PDPM Primary Condition Used for Case-Mix

AHCA is perplexed that in the first paragraphs of the SLP component comments on page 21049 of the NPRM, CMS explained that the SLP component case-mix approach needed to be separate from the PT and OT component because resident characteristics found to be predictive of SLP costs were inversely related to PT and OT costs and that *"… using the same set of predictors to case-mix adjust all three therapy components would obscure important differences in variables predicting variation in costs across therapy disciplines and make any model that attempts to predict total therapy costs inherently less Accurate."* Because the three therapy components of PDPM are to be determined independently, unlike RUGs, it would be relatively easy and makes sense to use separate "driving conditions" for each. However, in this NPRM, CMS proposes to force SNFs and the case-mix model to use the identical PDPM principal reason for stay condition code to determine the case-mix rate for all three disciplines.

While this approach may work well in a payment model design research project using an assumption that all resident admissions can only have one diagnosis attributed to a stay, in the real world it can create access issues for residents presenting with multiple recent-onset conditions that may require SLP services for an entirely different reason than the primary reason for PT and OT services. For example, it is clear from reviewing the proposed SLP case-mix weights on NPRM Table 23 and the PT and OT case-mix weights on Table 21, that acute neurologic conditions require relatively high SLP per-diem resources the same condition represents the lowest relative PT and OT per-diem use. The proposed PDPM model fails in real-world cases where the resident may present with an orthopedic condition representing the primary PT and OT condition, and an acute neurologic condition representing the primary SLP condition. The PDPM grouper forces the SNF to select a principal PDPM condition code that will either result in an inadequate case-mix payment for SLP services, or for PT and OT services during the stay. One or the other will be underfunded. As a result, beneficiaries with multiple complex needs, those residents PDPM is attempting to better serve, may experience access to care challenges.

Proposed Solution:

- **AHCA recommends an alternative solution to mitigate this risk. Specifically, the PDPM requirements should be revised to identify the PDPM condition code that most applies to the reason for SLP, if it differs from that identified for the PT and**

OT condition groups. This SLP "index-maximizer" approach could be achieved in two ways.

First, a second condition could be reported in the specific descriptive condition checklist items AHCA recommends being added to Section I of the MDS (e.g. a new section I8030 labeled *"Indicate the resident's primary PDPM clinical category"*) to represent the PT, OT, and SLP primary PDPM Clinical Category when the primary reason for SLP category differs from PT and OT (Our proposed checklist approach is discussed in our NPRM Section V.D.3.b. *Proposed Physical and Occupational Therapy Case-Mix Classification* comments above, as well as in Section 3 Subsection G Attachment A of these comments). The grouper software would then apply logic to apply the condition to the therapy component that best aligns with the most appropriate CMI index reflecting the higher resource needs within the respective therapy component.

A second approach, that would apply to providers selecting the CMS proposed option to enter ICD-10 codes in the first two fields of MDS Section I8000 to represent primary condition upon admission and hospital procedure codes (if applicable), would be to add a third code to represent the primary condition for SLP services (if applicable). If a code is present in row three of field I8000, the grouper would apply that code to the SLP case-mix determination rather than the row 1 code that is used for PT and OT CMI setting. If no code is entered in row 3, then row 1 is applied for SLP CMI determination.

iii. Reporting SLP Comorbidity Items on the MDS to Determine the SLP Case-Mix

We note that Table 9 of the *PDPM Calculation Worksheet for SNFs* (see below) indicates six of the 12 SLP-related comorbidities are proposed to be identified by information entered into existing MDS descriptive item fields, and that CMS would not be requiring detailed ICD-10-CM codes for the presence of conditions aphasia; CVA, TIA, or stroke; hemiplegia, or hemiparesis, or traumatic brain injury. However, CMS is proposing to require detailed ICD-10-CM codes to be entered for the other six SLP-related comorbidities of Laryngeal Cancer, Apraxia, Dysphagia, ALS, oral cancers, and speech and language deficits (in italics in Table 9 below) into MDS fields in I8000 because there are currently no check-box item fields currently on the MDS to report these conditions.

NPRM Table 9: SLP-Related Comorbidities

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis
I5500	Traumatic Brain Injury
I8000	*Laryngeal Cancer*
I8000	*Apraxia*
I8000	*Dysphagia*
I8000	*ALS*
I8000	*Oral Cancers*

I8000	*Speech and Language Deficits*
O0100E2	Tracheostomy Care While a Resident
O0100F2	Ventilator or Respirator While a Resident

We further note that Table 10 of the *PDPM Calculation Worksheet for SNFs* lists 53 distinct ICD-10-CM codes for the "oral cancers" condition group, and that the only difference between these codes are related to location of the neoplasm, and add no value to the PDPM classification beyond the SNF identifying that the person has a condition of an oral cancer. Since the individual ICD-10-CM codes for the SLP-related comorbidities add complexity and reporting burden to SNFs without impacting the SLP component case-mix determination, we offer the following recommendations:

Proposed Solutions:

- **We recommend that CMS instead add the six SLP-related narrative comorbidities categories that are proposed for ICD-10-CM code entry into a PDPM-required, SLP-related comorbidities check list added to Section I of the MDS. The MDS manual guidance could describe the clinical documentations that would support whether one of these condition items are checked as present, similar to how other existing MDS items are defined in the MDS manual.**
- **We recommend that these six items could be integrated into the existing SNF PPS assessment MDS Section I "Active Diagnoses in the last 7 Days" checklists (items I0200-I6300), or as a separate PDPM SLP-related comorbidities checklist similar to the current MDS I0020 item set.**
- **We also ask CMS to consider redefining the proposed SLP comorbidity "ALS" to be more inclusive of other progressive neurologic disorders that increase SLP resource use. Specifically, we recommend that the "ALS" SLP comorbidity be relabeled "Progressive Neurologic Diseases." The MDS manual definition for this item could define the specific progressive neurologic diseases that would meet this criterion.**

This recommendation would not preclude providers from entering ICD-10-CM codes into Section I8000 of the MDS (as proposed) that map to the SLP-related comorbidities if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently. However, we note that CMS has not provided any ICD-10-CM mapping for the six of the SLP-related comorbidities that would use existing MDS items, so providers that elect to submit ICD-10-CM codes would still be burdened by a need to complete these six MDS items.

iv. Transparent Process and Timeline for PDPM SLP Component Refinement

We have stated throughout the CMS process of developing the SNF PPS payment redesign model currently referred to as PDPM in this NPRM, our concerns that the model is based upon a foundation of using inpatient hospital diagnosis, other non-SNF data, and limited available MDS data as a proxy for new MDS items to be introduced and used to determine the SLP primary clinical categories that serve as the foundation for the respective case-mix groupings.

Proposed Solution:

- **AHCA recommends that CMS formalize a transparent process and timeline to refine the SLP component case-mix determination approach, particularly related to comorbidities and cognitive assessment, soon after the implementation of PDPM to better predict SLP resource use.**

iii. Nursing

CMS Request for Comment	AHCA Comments In-Brief

Page 21055 – We invite comments on the approach we are proposing above to classify residents for nursing payment under the proposed PDPM.	• Due to the lack of available data, AHCA has struggled with development of solutions for CMS. And, we remain concerned about the data sources upon which CMS had relied.
	• In the discussion below the Association discusses in detail our rationale for believing the nursing component likely is underfunded.
	• Short-Term Solutions for Making Expeditious Changes in Nursing Case Mix Group
	  ○ Initial/Admission Assessment – Build off the Current RAI Modification Provision to allow for case mix group adjustment as expeditiously as possible without the need for an IPA.
	  ○ Lengthen the Initial Assessment window from five to eight days to an outer limit of 14 days to allow more time for hospital information to become available.
	• Long-Term Solution – Because of the critical nature of nursing and the paucity of data, AHCA urges CMS to consider the Association's research on modern clinical practice and be prepared for early recalibration of the nursing component.

General Position Statement
AHCA views the consolidation to 25 case mix groups from 45 as positive as well as CMS efforts to address the STRIVE study issues, and the addition of Section GG. Nursing and related professional care are the cornerstone of SNF services and supports. Any changes must be carefully considered. AHCA remains concerned about the removal of nursing dollars to fund the NTAS component, that changes in medical practice are not adequately reflected in the nursing component, and despite CMS efforts we remain concerned about the use of STRIVE. Below we offer some assessment-based strategies to make expeditious changes in nursing case mix group assignment should the nursing component research be flawed.

1. Proposal Challenges

Below, we offer two areas of concerns with the PDPM proposal. The first focuses upon significant changes in clinical practices as well as how other health care providers

interact with SNFs. Our research on clinical practice is based upon quantitative analysis of patient characteristics, using claims and MDS, as well as an extensive survey of clinical professionals in SNFs. The second provides further observation on issues with use of STRIVE.

a. Clinical and Health Care Provider Operational Changes Impacting Nursing Care

CMS asserts a "key assumption" that "relative costs of nursing services across types of residents have remained stable since 2006-2007." The evidence is incomplete. And, we point out that since 2006-2007 an array of significant changes have occurred impacting nursing and professional clinical care. First, AHCA conducted a survey of SNF clinical professionals. The survey was divided into sections to address:

- Increased use of medications that require clinical professionals
- Change in use of technology that also require additional clinical expertise
- Increases in the number of patients who require complex care
- Barriers to obtaining data from hospitals and physicians. The latter also would impact SNFs' ability to accurately assign a patient to the appropriate nursing case mix group.

Below, we summarize qualitative findings by section.

i. Change in Use of Drugs

New drugs used in the hospital and/or prescribed at discharge affect nursing care in SNFs. A number of these drugs require additional nurse monitoring time. For example, SNFs are admitting more patients with IV medications. A significant number of SNFs have not historically had staff with training and the capacity for managing IV drugs. AHCA recognizes CMS has included an NTAS classification titled, "Special Treatments/Programs: Intravenous Medication Post-admit Code," drawn from MDS Item O0100H2 with a point assignment of 5, one of the higher NTAS point scores. However, we question whether CMS has accounted for the total nursing time associated with monitoring IV medications as well as other now more prevalent complex medications including:

- Cardiac medications
- Oral Cancer medications requiring monitoring, along with follow-up with Procrit or Neupogen
- Complex anti-coagulants
- Diabetes, pain, cardiac, and other drugs delivered by pump
- Complex IV antibiotics for drug resistant infections, involving new procedures and training
- Psycho-pharmaceuticals

The impact of these drugs on nursing includes the demand for more specialized nursing, more training, and additional time involved in monitoring patients. With regard to psycho-pharmaceuticals, respondents noted major efforts to decrease the use of these drugs in relation to dementia, and report the increased use is associated with seeing an increased volume of patients diagnosed with major mental illness. However, we recognize CMS has included two nursing case mix groups titled Behavioral or cognitive symptoms, 2 or more, and a second of the same title but with 0 to 1. And we also appreciate CMS' efforts to investigate the adequacy of resources available to patients with behavioral health needs as well as other subpopulations in the Impact Analysis discussed on page 21076. CMS notes in its analysis a significant increase in the number of stays which included IV medication as well as behavioral symptoms.
However, as CMS has noted, the data and methods used for PDPM design are based upon a research project and not real-world operations, therefore our concerns linger. Specifically, if payments are not adequate, SNFs may or may not be able to accept patients in need of these medications.

ii. Increased Use of Specialized Equipment & Technology

As new technology becomes available both in the hospital and for management of chronic illness, patients are admitted to the SNF with new technologies. Each new technology requires staff be trained in its use, monitoring, and maintenance. As a result, many SNFs do not accept some technologies. Other nursing intensive technologies have been in use for some time but are being used more frequently because of changes in clinical practice. For example, CPAP/BiPAP and assisted respiratory services have been used for some time and clinical practice has increased focus on sleep quality and interrupted sleep. Other examples of increases and changes in technology in the SNF over the last 10 years include:

- CPAP/BiPAP[2]
- Ventilators and new respiratory assist devices (e.g., Trilogy)
- Drug administration pumps
- LVADs, AEDs, Life Vests (newer technologies for cardiac patients)
- Wound vacs and technology for complex wound treatment
- Anti-embolic equipment
- Bariatric equipment
- Telemedicine
- EKGs

As in the case of newer drugs that require special training and monitoring, many buildings will not accept patients with these technologies. There have been increases in the number of SNFs that accept these technologies, but clinical experts note in their comments that many of these technologies can take up to two hours or more per patient

[2] AHCA is aware CMS removed CPAP and BiPAP from the NTAS list. We are concerned about nursing resources to monitor and manage this equipment.

day of nursing time to support their use, not counting the training and specialized expertise that may need to be added to the SNF's clinical capacities.

iii. Increases in Special Therapies and Complex Care

These categories of care focus more on clinical areas of programming SNFs are expected to provide. Each type of special therapy or complex care requires training and specialization in nursing or specialized consultant staff. Each has implications for additional time in care delivery on a daily basis. Special therapies that have increased over the last decade include:

- Tracheostomies, Chest Tubes, Arterial blood gases
- TPN
- Large complex open wounds
- Ostomies
- Dialysis shunts
- Ventilator dependence
- Cardiac monitoring
- Bariatric care
- Behavioral health care, particularly for psychiatric illness

Most of the facilities offering these services indicate gradual increases over the last decade in volume. Clinicians also note steady migration of these services into buildings that had not historically provided the service, but generally in SNF chains with many buildings. While some evidence of these areas of complex care are reported in the MDS, others are not and may not be comprehensively reported. Again, we appreciate CMS' examination of subpopulations in its Impact Analysis but have included recommendations to strengthen PDPM implementation and operations.

iv. Increased Complexity of Clinical Care and its Impact on SNFs

Clinicians also report increases in complexity of care have had a moderate to significant impact on nursing staff over the last decade. These increases are attributable to patients with more comorbidities and an increased average age. Both age and multiple comorbidities are associated with patients admitted from hospitals "sooner and sicker (see Section F, Payment Methods discussion).

v. In spite of CMS improvements in its use of STRIVE, concerns remain.

The validity of STRIVE data is hobbled by widely held concerns about its representativeness, reliability, and accuracy. AHCA and others have previously expressed grave concerns about the representativeness, reliability, validity, and accuracy of the nursing and therapy weights developed based on data from STRIVE. CMS itself ruled out using STRIVE as a basis for Five-Star staffing risk adjustment based on concerns of numerous stakeholders about the predictive power of the STRIVE-based system. AHCA

appreciates the steps CMS describes on pages 20153–21055 but believes steps will be required to ensure patient access and payment accuracy early in PDPM implementation.

vi. Use of Section GG Late Loss and Early Loss ADLs will Present Implementation and Classification Challenges

CMS will need to build in time for SNF staff to better understand Section GG and to assess the quality of Section GG data. AHCA MDS experts note that coding accuracy for Section GG has been problematic for SNFs during the recent introduction of these items, particularly due to 1) the shorter assessment reference period and 2) an inverse scoring scale than used in the Section G items that assess the same functions. We believe these challenges will still remain as long as both sections related to function are still required to be reported for OBRA assessments and for states, Medicare Advantage plans, and other payers that do not convert PDPM.

Recommendations: *Due to the lack of available data, AHCA has struggled with development of nursing component solutions for CMS. Below, we offer solutions that are discussed in more detail in Section G – MDS and IPA. We also believe this component, in particular, may drive the need for early adjustments in PDPM.*

In the ***short-term***, AHCA proposes that CMS in partnership with SNF stakeholders make two key changes to ensure patient access and payment accuracy.

a. Initial/Admission Assessment – Build off the Current RAI Modification Provision

Chapter 3, Section A of the current RAI Version 3.0 Manual discusses a 2013-implemented MDS modification process. The modification provision may be used for typographical errors.

AHCA suggests CMS alter the existing modification provision, specifically the clinical items (B0100-V0200C), to allow providers to make adjustments in the admission MDS as additional information arrives from the hospital and/or more is learned from patient observation. This would be a notable change from the existing typographic error correction focus on the current modification provision.

b. Lengthen Initial Assessment Window

We further propose that the window for such modifications be any day from day one through 14 days from admission. This modification would be a change to the initial assessment of five to eight days. Supporting medical documentation would be required as justification and for future auditing purposes.

c. Short- and Long-Term Recalibration

CMS has characterized Acumen's SNF Payment Model work as a research project. The Acumen research, based on hospital data, is not indicative of SNF care and only is an approximation of real world impacts on SNFs and patients, specifically the complexity of patients and the proportion of patients who have medically complex care needs. AHCA once again raises concerns with CMS' ability to assess changes in medical practice and medical technology. To address challenges Acumen research assumptions, which drive case mix group assignment and design, and case mix indices, CMS should have plans in place for near-term recalibration as well as longer-term (see Section J, Budget Neutrality and Recalibration). Regarding the former, CMS should be prepared to recalibrate as soon as six months into implementation to address any and all of the factors noted, above.

d. IPAs Should Not be Triggered for Successful Treatment of Admitting Conditions

Because the PDPM model was designed based upon the average episode costs for care for residents with specific characteristics upon admission, which are then converted into per-diem rates, we do not believe that a SNF should be penalized via the IPA assessment process to be required to complete an IPA assessment and thus receive lower per-diem payments as a result of successfully treating a condition present on admission. For example, the presence of depression on admission can impact the PDPM Nursing component CMI. The resolution of depression would reflect a positive outcome, and the effort of care planning and maintaining the absence of depression through the remainder of the stay is generally more resource intensive than treating a person who was not admitted with depression. In such cases, the IPA should not be triggered. In the IPA section of our comments we request clarification regarding whether CMS' intent is the first tier only for reclassification or whether other characteristic changes might trigger an IPA. See Section G for more detail.

vii. Non-Therapy Ancillary Services

CMS Request for Comment	AHCA Comments in Brief

Page 21059 – We invite comments on the approach proposed above to classify residents for NTA payment under the proposed PDPM.	• Initial Admission Assessment – Build on the Current RAI Modification Provision to Allow for Adjustments without an IPA
	• Develop an IPA Threshold for NTAS Reset to Day One
	• Create a NTAS Default Category
	• Clarify:
	  ○ Changes on Conditions and Services List from RCS-1 List
	  ○ Low Point Assignments for High-Cost and Ongoing Conditions and/or Service Needs
	• AHCA does not support the proposed PDPM ICD-10 diagnosis approach to reporting NTA condition items on the MDS to determine the NTA case-mix
	  ○ AHCA recommends an alternative approach to add the newly identified NTA Condition items to an existing MDS checklist item set to determine the NTA case-mix under PDPM

General Position Statement

As AHCA noted in its August 2017 Advanced Notice Comments, we appreciate the addition of more comorbidities that offer additional nuance to NTAS payments. For PDPM, we also appreciate CMS' analysis using FY 2014–FY 2017 data. However, AHCA remains concerned about such a prescriptive approach which attempts to predict NTAS costs when such a methodology is not supported in literature or by "real-world" SNF usage data analysis. At a minimum, AHCA believes provisions need to be added to address care for specialty populations and very high-cost condition and/or services that do not allow for tapering. We also believe the proposed MDS ICD-10 coding for some NTA conditions is burdensome and offer an alternative approach.

In the Fiscal Year 2012 proposed rule, CMS proposed a more nuanced approach to an NTAS component that included both routine NTAS payments and non-routine NTAS payments for higher cost items. AHCA understands the parameters of the Acumen research were to remain within CMS' existing statutory authority and to rely upon existing administrative data. However, AHCA research indicates that NTAS costs are virtually impossible to predict through use of existing administrative data. The proposal assumes NTAS costs are predictable and AHCA believes the NPRM, while expanded, remains a very simplistic approach to a very complex service area.

Furthermore, we are deeply concerned about the adequacy of funding the proposed NTAS component using very old data and using the proportion of the current nursing component costs assumed to be NTAS costs. The estimate dating back to the early 2000s is approximately 43 percent. As we discuss in the Nursing Component discussion above, nursing practice fundamentally has changed in the past 16 years along with significant advancement in medical technology that has been brought to market since the 1995 base year, and such a simplistic

approach is like inaccurate and could prove highly problematic.

Nursing and related professional care is the cornerstone of SNF care. What appears to be a rough estimate of funds removed from nursing to fund NTAS could destabilize nursing care and seriously impact access, quality, and outcomes to SNF care for Medicare beneficiaries. We consider this a critical flaw in the overall design which must be addressed before any further work is conducted on an NTAS component that is funded by the nursing component.

Finally, we are concerned about the excessive burden and compliance risk associated with the proposed ICD-10-CM reporting requirements for some, but not all, of the proposed conditions attributed to higher NTA costs and case-mix assignment. We propose a simplified alternative solution below.

1. Challenges with Proposal

The entire PDPM proposal for an NTAS component is premised upon the validity of its cost-per-day model based on charges on claims and reduction of charges to cost based on cost-to-charge data derived from facility cost reports. The assumption underlying this model is that NTAS costs can be predicted. AHCA questions whether this is a reasonable point of departure for design of a payment policy. Rather, we begin with the rationale for the need for an NTAS payment policy. The longstanding concern asserted by MedPAC and CMS is that NTAS can account for significant cost that is not adequately compensated by the nursing component. Prior research suggests that nursing case mix does not correlate with NTAS cost. If NTAS costs are clustered around an average range of cost without significant "high cost outliers," then prediction might be reasonable.

However, the distribution of costs for very high-cost patients is volatile such that the costs of NTAS could not be absorbed by the facility based on payments for average costs. In turn, SNFs will be reluctant to admit patients with the likelihood of especially volatile high-cost NTAS needs. This likely provider behavior negates a key goal of CMS' payment reform effort – to reduce barriers to care for medically complex patients. Rather, with the existing NTAS design, CMS simply has created a new version of a payment disincentive to admit medically complex patients with the need for high-cost intensive interventions.

As CMS is aware, drugs have long been assumed to make up the majority of NTAS costs. To better understand this issue, AHCA's researchers conducted a study of about 50,000 Part A SNF stays using donated pharmacy data to understand the distributions and patterns in the costs for drugs. In brief, the findings indicate high-cost drugs are generally a low-frequency occurrence, and that about two-thirds of SNF stays involved NTAS drug costs in the range below $30/day. The one-third of SNF stays with costs above $30/day cluster around costs per day in a moderate range and then about 5% of stays involve very high costs in the range of $200 per day or higher. The higher cost range is a threat to facility viability, patient access, and medical capacity expansion.

Therefore, any predictive model that cannot precisely target these high-cost cases will fail from a policy perspective because it will routinely overpay providers whose data conforms to

the predictive model and underpay the actual high-cost cases that cannot be predicted. Our researchers conclude that high-cost NTAS cannot be predicted based on patient characteristics from existing administrative data with the precision required to address the policy problem, regardless of statistical results, and because of the nature of the clinical practice.

Our researchers furnished an example based on drug utilization, or anti-infective drugs. The recent study shows that a large proportion of patients utilize relatively inexpensive anti-infective drugs, and a smaller but moderate proportion of patients utilize anti-infective drugs in the $18-$25 range, which largely reflects higher dispensing fees associated with providing supplies for IV medications. There are a fair number of anti-infective drugs that are relatively expensive on a payment per day supply basis, but utilization of these drugs is quite low. The distribution of costs per day for the range of anti-infective drugs used in the SNFs studied is discussed, below.

While patient characteristics may identify patients needing anti-infective drugs with or without IV therapy, these data cannot predict the utilization of this range of cost. Upon a closer look at all drug utilization in the study, of 11 medications in the $200-plus payments per day supply category, three (or 27 percent) were anti-infective medications. There were also three medications identified as hematological agents and two identified as antineoplastic agents. Of the patient stays where one or more medications in the $200-plus payments per day supply category, 81 percent were for one of the three anti-infective drugs. These drugs included in order of utilization frequency:

- Linezolid (used for treatment of gram-positive bacteria resistant to other antibiotics including VRE and MRSA)
- Fidaxomicin (used for treatment of pathogenic Clostridium difficile)
- Posaconazole (used as an anti-fungal for treatment of Candida and other species in immunocompromised patients)

This example illustrates that high-cost NTAS are likely to be a highly specific clinical response to a complex problem that occurs infrequently and cannot be predicted.

We also believe diagnosis codes are poor predictors of high-cost NTAS. The distribution of patients with a given acute or chronic illness will, in most cases, be treated with an array of drugs or other interventions. While there may be a few conditions with predictable NTAS costs (e.g., HIV, transplant status, ventilator dependence), these are very low frequency situations and they are not representative of other conditions with a broader array of possible treatment options. While the Association appreciates CMS' focus on simplicity and use of multiple years of data in its analysis, we are concerned that no NTAS list is exhaustive nor can capture all patient NTAS needs. Stated another way, no static list can predict all possible patient needs.

Finally, in regard to the NTAS tapering proposal, we, again, note the unpredictable nature of NTAS needs as well as the fact that in certain cases the need for and cost of NTAS does not taper over time. For example, the cost of 24/7 ventilator rental can easily exceed $300 per day. A 100-

day stay for a ventilator patient, therefore would cost $30,000 just for the ventilator. However, the NTAS payment (including far more than just the routine ventilator services at an ND NTAS Level with a score of 4 points) would be only $10,586 or three days at $299.60 plus any additional days at $99.87. As discussed in the Association's Variable Payment section, when conditions that require high-cost medications or equipment emerge mid or late in a stay, the Interim Payment Assessment (IPA) does not allow SNFs to draw down needed funding for care because the IPA does not allow the NTAS component to return to Day One.

Such a scenario creates an unintended linkage to the Interrupted Stay Policy. Specifically, due to the inflexibility of the IPA policy, CMS has built in an incentive for providers to discharge patients back to hospitals where such medications or equipment can be dispensed or ordered and the costs absorbed by the hospital. We believe the financial impact of these NTAS outweigh any SNF Value-Based Purchasing Rehospitalization Program penalties. Also, such a scenario is likely regardless of whether the interrupted stay is less than or equal to three days or more than three days. The hospital physicians' discharge orders would include the new medication or equipment. Therefore, the length of the interrupted stay is moot. Again, as currently designed, we believe PDPM is continuing and expanding current PPS issues rather than solving challenges.

Finally, CMS notes "those conditions and services with a greater impact on NTAS costs are assigned more points while those with less of an impact are assigned fewer points." However, clinicians note an array of conditions have low point assignments considering related NTAS costs. Examples include morbid obesity requires new equipment and supplies upon admission including but not limited to a specialty bed and an array of other materials and equipment (recommend increasing this area to 2 points). Below, we offer other examples. Additionally, Association notes decreases in the NTAS points in PDPM compared to those assigned under RCS-1. See Table 1, below.

2. Proposed Solutions and Requests for Clarification

AHCA respects CMS' focus on moving forward expeditiously with PDPM but believes steps should be taken to ensure longstanding RUGs issues truly have been addressed without new challenges replacing the old and that CMS has created an NTAS payment policy that meets all patients' needs. The Association offers the following solutions:

a. Request for Clarification on PDPM Conditions and Extensive Services Changes

The Association notes an array of changes in the NTAS Conditions and Extensive Services list. We request clarification on the addition of new items as well as changes in points assigned to items that also were included in RSC-1 version and carried over into PDPM. See ***Table 1***, below, for more detail. CMS notes certain analytic steps, including the FY 2014 to FY 2017 data analysis, but does not explicitly explain the changes. ***Recommendation/Clarification:*** *We request CMS clarify the NTAS list changes.*

Table 1. Differences between RCS-1 and PDPM NTAS Component

Payment System	RCS-I	PDPM
Number of Conditions/Service Items	28 different conditions or extensive services	50 different conditions or extensive services
Changes in List		**Items Removed**: - Kidney Transplant status - Transplant - Osteomyelitis - Chemo therapy **Items Added New**: - Chronic Myeloid Leukemia - Immune disorders - Narcolepsy and cataplexy - Specified hereditary metabolic/immune disorders - Morbid obesity - Psoriatic arthropathy and systemic sclerosis - Chronic pancreatitis - Proliferative diabetic retinopathy and vitreous hemorrhage - Other foot skin problems, foot infection, other open lesion on foot, except diabetic foot ulcer (M01040A, B, C) - Complications of specified implanted device or graft - Intermittent catheterization (H0100D)

Payment System	RCS-I	PDPM
		- Inflammatory bowel disease - Aseptic necrosis of bone - Cardio-respiratory failure and shock - Myelodysplastic syndromes and myelofibrosis - Systemic lupus erythematosus, other connective tissue disorders, and inflammatory spondylopathies - Diabetic retinopathy – EXCEPT Proliferative diabetic retinopathy and vitreous hemorrhage - Feeding tube (K0510B2) while a resident - Severe skin burn or condition (I8000) - Intractable epilepsy - Malnutrition (I5600) - Disorders of Immunity (except RxCC97: Immune disorders) - Cirrhosis of liver - Ostomy (H0100C) - Respiratory arrest - Pulmonary Fibrosis and other Chronic lung disorders
Changes in Scoring	Scoring for NTA Case Mix Group: 64 total points available 11+ NA 8-10 NB 6-7 NC 3-5 ND 1-2 NE 1 NF 6 Case-Mix groups	Scoring for NTA group **86 total points available** (all new items are valued at 1 point, except chronic Myeloid Leukemia =2) **12+ NA** **9-11 NB** **6-8 NC** 3-5 ND 1-2 NE 0 NF 6 Case-Mix groups

b. Low Point Assignments

On page 21057 of the NPRM, CMS notes, "points are assigned by grouping together conditions and extensive services with similar ordinary least squares (OLS) regression estimates. The regression used the selected conditions and extensive services to predict NTA costs per day. More information on this methodology and analysis can be found in section 3.7.1 of the SNF PDPM technical report." As discussed in the examples, above, we are concerned about low point assignments for certain conditions including morbid

obesity (discussed above – we recommend increasing points from 1 to 2), the highest stage of a pressure ulcer stage 4 should also include unstageable necrotic and, again, the equipment and supplies all are high-cost and/or ongoing – we recommend increasing the points to 2 from 1. Similarly, we believe skin burn should be increased to 2 points as well as tube feeding. As with the preceding items, the latter two both require an array of specialty medical items and over the course of a stay and decline in the need for these items is unpredictable. ***Recommendation/Clarification:*** *We request clarification on how the low point scores for these items were developed and further discussion in regard to why CMS believes the points are sufficient.* The Association is concerned these items are not accurately scored relative to needed care and could result in access issues perpetuating the RUGs IV problem CMS is attempting to solve.

c. Create a Default NTAS Category

As discussed above, the Association does not believe NTAS use is predictable nor is it flexible enough to reflect what we know will be changing conditions and increases in medically complexity in the future. The Association also believes conditions and extensive services will appear that are not included in the proposed conditions and services list. Given the significant change in acuity and increases in intense clinical services we have seen since the last SNF PPS system was adopted, we believe greater flexibility and faster responsiveness to new conditions and services that would be expected in our settings should be addressed. In response to this challenge, we propose the development of a "default" item that would capture these conditions and items at admission or when an Interim Payment Assessment is needed. For simplicity, payment for these conditions and items could be based upon similar items that are included in the list and the case mix index (CMI) modifier developed for conditions and items that are determined to cost more than the already existing item and related CMI. Upon recalibration (see Section J Budget Neutrality and Recalibration), CMS should revisit the NTAS Conditions and Services list to address default items and other changes. ***Recommendation:*** *We request CMS explore the creation of a default and provide an explanation of its findings.*

d. Recommendations to Address the NTAS Day 1 Issue

As we have noted in the payment methods section of our comments, we believe the blanket prohibition on returning the NTAS component to Day One is a fundamental flaw in PDPM, which could result in patient access issues, increased rehospitalizations, and financial hardship for SNFs. We offer two solutions – 1) modification near admission; and 2) a proposal to return to Day One with certain IPAs.

i. Initial/Admission Assessment – Build upon the Current RAI Modification Provision and Lengthen Assessment Window

Chapter 3, Section A of the current RAI Version 3.0 Manual discusses a 2013-implemented MDS modification process.

AHCA suggests CMS alter the existing modification provision, specifically the clinical items (B100–V0200C), to allow providers to make adjustments in the admission MDS as additional information arrives from the hospital and/or more is learned from patient observation. We further propose that the window for such modification be 14 days from Assessment Reference Date for the Admission Assessment. This modification would be a change to the initial assessment and would not be an IPA. Supporting medical documentation would be required as justification and for future auditing purposes.

ii. Develop IPA Threshold for NTAS Reset to Day One

CMS has proposed a points system for the NTAS component. To address care needs that emerge mid to late stay for high-cost NTAS, AHCA recommends CMS work with stakeholders to develop a threshold of additional NTAS points that would allow providers to reset the NTAS variable per-diem to Day One. The Association envisions the NTAS component resetting to Day One if a patient's NTAS score increases by two or more points. The Association would welcome the opportunity to work with CMS identifying the appropriate threshold.

e. Proposal to Report All NTA Condition Items in Checklist Format on MDS

We note that Table 12 of the PDPM Calculation Worksheet for SNFs indicates that nine of the 50 NTA-condition/extensive service comorbidities are proposed to be identified by information entered into existing MDS descriptive item fields, and that CMS would not be requiring detailed ICD-10-CM codes for the presence of conditions of major organ transplants, chronic lung diseases, wound infections, diabetes, diabetic foot ulcers, multi-drug resistant organisms, stage 4 pressure ulcers, other foot skin problem (infections/lesions), and malnutrition. However, CMS is proposing to require detailed ICD-10-CM codes to be entered for 28 NTA-related condition comorbidities of MDS fields in I8000, accounting for 1,552 unique ICD-10-CM codes, because there are currently no check-box item fields on the MDS to report these conditions.

Similar to our SLP-related comorbidity comments (see Section 3, Subsection E, ii), we note that the additional code detail beyond the broad narrative category description adds no value to the PDPM classification beyond the SNF identifying that the person has a condition identified in Table 27 of the NPRM. Since the individual ICD-10-CM codes for the NTA-related comorbidities add complexity and reporting burden to SNFs without impacting the NTA component case-mix determination, we recommend that CMS instead add the 28 NTA-related narrative conditions categories that are proposed for ICD-10-CM code entry into a PDPM-required, NTA-related conditions check list added to Section I of the MDS. For example, a majority of the proposed NTA-related condition coding specificity is related to body regions, tests, procedures, and other details related to inpatient hospital care and billing requirements not readily available to the SNF. We propose the MDS manual guidance could describe the clinical documentations that would support whether one of these condition items are checked as present, similar to how other

existing MDS items are defined in the MDS manual.

We recommend that these 28 items could be integrated into the existing SNF PPS assessment MDS Section I "Active Diagnoses in the Last 7 Days" checklists (items I0200-I6300), or as a separate PDPM NTA-related conditions checklist similar to the current MDS I0020 item set.

This recommendation would not preclude providers from entering ICD-10-CM codes into Section I8000 of the MDS (as proposed) that map to the NTA-related conditions, if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently. However, we note CMS has not provided any ICD-10-CM mapping for the nine of the NTA-related conditions that would use existing MDS items, so providers that elect to submit ICD-10-CMs codes would still be burdened by a need to complete these nine MDS items in addition to ICD-10-CM codes for the other 28 possible conditions.

Subsection F. Payment Methods

CMS Request for Comment	AHCA Response In-Brief

Page 21061 – We invite comments on the proposed variable per-diem adjustment factors and payment schedules discussed in this section.	• Variable payment likely will have unintended consequences due to unpredictable patient care needs
	• Setting variable per-diem day one case mix groups is problematic due to late emerging patient needs and/or significant delays in the arrival of medical information from the hospital or physician
	• Proposed Solutions:
	  ○ Allow modifications to the 5-8 Initial Assessment
	  ○ Lengthen the initial assessment window to up to 14 days
	  ○ Created a threshold for waiving the day one prohibition on NTAS reset
	  ○ Initiate research on specialty populations

General Position Statement
AHCA believes variable per-diem must be assessed against existing SNF requirements, the unpredictable nature of patient care, and proposed assessment policies. We believe the first two issues relative to variable payment can be addressed through changes to the assessment proposals. Without such changes, we believe variable payment will perpetuate beneficiary assess issues and create significant operational provider burden.

Specifically, AHCA believes the interaction of variable payment methods, the proposed MDS schedule, and the proposed IPA policy will create barriers to SNF capacity to meet Requirements for Participation Sections 483.24 Quality of life and Section 483.25 Quality of Care, negatively impacting patient access and resulting in under funding. The Association also believes these policies will combine to produce unintended provider use of the interrupted stay policy.

1. Unintended Consequences

Sections 483.24, Quality of Life, and 483.25, Quality of Care, indicate SNFs require that each resident receive and the facility provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. AHCA supports these provisions. However, the Association also believes the combined effect of the current variable payment schedules with MDS and IPA policies will result in scenarios in which providers will struggle to, or be unable to, meet patient needs and these RoP sections.

a. Unpredictable Patient Care

In the past decades, the average hospital stay has decreased from 7.3 days to approximately 4.5 and other research shows patients are older and sicker. Yet, patients are being discharged earlier. Hospital resource use measures, observation stays, physician payment pressures, and alternative payment methods have greatly accelerated the trend towards shorter hospitals stays, which began with implementation of the Inpatient Prospective Payment System (IPPS).

Additionally, patients' needs change and often require medications due to conditions that emerge later in their stay. These items would not be captured in the five- to eight-day assessment. While patient characteristics may identify patients needing anti-infective drugs with or without IV therapy, these data cannot predict the utilization of this range of cost. For example, infrequent but very costly infections do occur. The three most common drugs are:

- Linezolid (used for treatment of gram-positive bacteria resistant to other antibiotics including VRE and MRSA)
- Fidaxomicin (used for treatment of pathogenic Clostridium difficile)
- Posaconazole (used as an anti-fungal for treatment of Candida and other species in immunocompromised patients)

These are examples of high-cost NTAS which are likely to be a highly specific clinical response to a complex problem that occurs infrequently and cannot be predicted. Without the ability to reset the variable per-diem schedule, this certainly would negatively impact a SNFs ability to respond to such patients' care and comply with RoP elements.

AHCA proposes that CMS in partnership with SNF stakeholders make two key changes to the assessments that would make the variable payments better align with SNF RoP requirements and AHCA members' commitment to quality care.

Recommendations:

- *Initial/Admission Assessment – Build on the Current RAI Modification Provision*

Chapter 3, Section A of the current RAI Version 3.0 Manual discusses a 2013-implemented MDS modification process.

AHCA suggests CMS alter the existing modification provision, specifically the clinical items (B0100–V0200C), to allow providers to make adjustments in the admission MDS as additional information arrives from the hospital and/or more is learned from patient observation. With these changes the existing modification provision no longer would be for typographical reasons but also for changes in clinical status based upon

new medical information from a hospital or physician. This modification would be a change to the initial assessment and would not be an IPA. Supporting medical documentation would be required as justification and for future auditing purposes.

- *Length the 5-8 Day Assessment Window to an Outer Boundary of 14 Days*

We further propose that the window for initial assessment be between one and 14 days from Administrative Reference Date for Admission. This would allow more time for a SNF to assess patient needs and, potentially for more medical information to arrive from the hospital or from a physician. SNFs still would adhere to the current requirement that a plan of care be developed within 48 hours.

b. Ongoing Care Needs and Adjustment

AHCA believes the proposed assessments the IPA and the Interrupted Stay Policy, while addressing "typical" patient care, do not address the care needs of higher cost, sicker patients or atypical skilled care needs. First, patient needs often do not fully present themselves within the five- to eight-day window for the initial assessment CMS discusses on page 21062. Second, as in the medication examples, above, a SNF clinical professional and an MDS coordinator are highly unlikely to have any information that would indicate the need for such medications or other high-cost items at the point of admission.

Later, when conditions that require such medications or equipment emerge, the IPA does not allow SNFs to draw down needed funding for care because the IPA does not allow the NTAS component to return to Day One. Such a scenario creates an unintended linkage to the interrupted stay policy. Specifically, due to the inflexibility of the IPA policy, CMS has built in an incentive for providers to discharge patients back to hospitals where such medications or equipment can be dispensed or ordered and the costs absorbed by the hospital. We believe the financial impact of these NTAS outweigh any SNF Value-Based Purchasing Rehospitalization Program penalties. Also, such a scenario is likely regardless of whether the interrupted stay is less than or equal to three days or more than three days. The hospital physician's discharge orders would include the new medication or equipment. Therefore, the length of the interrupted stay is moot.

Recommendations:

- *Develop IPA Threshold for NTAS Reset to Day One*

CMS has proposed a points system for the NTAS component. To address care needs that emerge mid to late stay for high-cost NTAS that is outside CMS' concept for tapering, AHCA recommends CMS work with stakeholders to develop a threshold of additional NTAS Points that would allow providers to reset the NTAS variable per-diem to Day One. The Association envisions the NTAS component resetting to Day One if a patient's

NTAS score increases by possible two or more points. The Association would welcome the opportunity to work with CMS identifying the appropriate threshold. See Section G for a full discussion of our reset concept.

- *Clarify IPA Criteria*

We discuss further in Section G, there is some confusion within the provider community about whether the intent is to only require these assessments if there is a **first-tier change,** because the proposed rule goes on to say, "To clarify, the change in classification group described above refers to not only a change in one of the first tier classification criteria in any of the proposed payment components, but also to one that would be sufficient to change payment in either one component or in the overall payment rate …," which some are interpreting as meaning any change that would cause a change in payment (such as change in ADL score for example) would require an Interim Payment Assessment, not just those that relate to first-tier payment items.

Because the PDPM model was designed based upon the average episode costs for care for residents with specific characteristics upon admission, which are then converted into per-diem rates, we do not believe a SNF should be penalized via the IPA assessment process to be required to complete an IPA assessment and thus receive lower per-diem payments as a result of successfully treating a condition or functional deficit present on admission. The IPA should be limited to unplanned and unexpected resource use need changes.

For example, in the case of the PT and OT components, a resident may be admitted with a case-mix index that it based in part on the admitting functional status, with a plan of care to improve that function with a goal to return home. The planned improvement of function to a different functional score threshold during the stay is a positive outcome, and the effort of care planning to continue that improvement through the remainder of the stay until the resident returns home does not reduce the resource needs to achieve that goal. In such cases, the IPA should not be triggered. As part of this work or in response to our IPA comments, CMS should clarify the criteria for an IPA.

c. Specialty Populations

AHCA also has continuing concerns related to potential unintended PDPM consequences for certain beneficiary populations. Such unintended consequences may include reduced access to services and/or greater out-of-pocket costs as a percentage of Medicare's payment to providers. In particular we are concerned about beneficiaries whose diagnosis and/or condition creates a certainty that a full 100-day benefit period with daily skilled services will be utilized. In such cases, the tapering effects of the variable payment rate adjustments for the PT, OT, and particularly NTA rate components may erode payment to the point where average payment for the stay is below the actual direct cost of providing the services. This scenario may result in access issues for patients with specific diagnoses/conditions for whom high-cost medications and/or daily use of costly medical

equipment does not taper over time and for whom therapy services maintain or slow down the progression of degenerative chronic conditions.

Due to these challenges, Medicare costs will go up due to unneeded hospital readmissions, SNFs will experience higher rehospitalization rates because they will be financially unable to comply with RoP Sections 483.24, Quality of Life, and 483.25, and patients may undergo needless traumatic transfers.

Recommendation:

- *Strategy to Address Specialty Populations*

CMS should study and provide a detailed report on the characteristics of beneficiaries in a PDPM simulation period who had SNF stays that exceeded 90 days in length to determine whether it creates potential access issues for such beneficiaries. CMS should consider creating a "tapering waiver" for NTAS tapering to mitigate access issues for such patients or apply the modification proposal discussed, above

Subsection G. MDS, IPA, and Interrupted Stay Policies

AHCA has combined its comments on the Minimum Data Set, Interim Payment Assessment (IPA), and Interrupted Stays into a single section. We believe the lines of inquiry all are interrelated. In this section we offer comments in response to request for comments on page 21063 on Interim Payment Assessment (IPA); page 21065, revisions to the SNF PPS reschedule and related provider burden; page 21065, addition of items to the SNF PPS Assessment (Discharge for Therapy Monitoring); and page 21070, inappropriate use of the proposed interrupted stay policy. In brief, AHCA offers the following comments. Detailed comments are below.

NPRM Comment Request	AHCA Comments
Page 21063 – We invite comments on these [IPA] proposals.	- IPA as proposed creates new SNF burden - CMS should clarify what patient characteristic changes trigger an IPA - Thresholds should be set in IPA policy for NTAS to be reset to Day 1 in certain scenarios
Page 21065 – We invite comments on our proposals to revise the SNF PPS assessment schedule and related policies as discussed above. We also solicit comment on the extent to which implementing these proposals would reduce provider burden.	- ICD-10 codes are not needed nor required on the admission MDS and AHCA offers an alternative approach (see Section G Attachment A for more detail) - SNFs still will be required to update assessments to maintain an up-to-date Comprehensive Person-Centered Plan of Care - OBRA required assessments continue - These issues combined with the current IPA concept will increase SNF burden relative to the current MDS and Other Required Medicare Assessment (OMRA) schedules
Page 21065 – We invite comments on our proposals above to add items to the SNF PPS assessment (discharge for therapy monitoring).	- AHCA strongly opposes the reporting of therapy services in Section O of the SNF PPS Discharge MDS under PDPM as proposed - AHCA recommends an alternative solution where the reporting of similar information of therapy services on claims better serves to achieve the CMS intent while limiting provider burden - AHCA recommends that in evaluating the impact of PDPM implementation on therapy service delivery patterns, CMS must do so in the context of the impact on CMS-developed quality and outcomes measures that are commonly associated with effective rehabilitation services
Page 21070 – We invite comments on the [interrupted stay] proposals outlined above. We would also note that we believe that frequent SNF readmissions may be indicative of poor quality care being provided by the SNF. Given this belief, we plan to monitor the use of	- AHCA supports an interrupted stay policy but with modification o The number of days (</= 3; >3) should not matter, rather the patient condition

NPRM Comment Request	AHCA Comments
this policy closely to identify those facilities whose beneficiaries experience frequent readmission, particularly facilities where the readmissions occur just outside the three-day window used as part of the interrupted stay policy. Should we discover such behavior, we will flag these facilities for additional scrutiny and review and consider potential policy changes in future rulemaking.	SNFs are required to re-assess at admission for care plan development o The same parameters as under our IPA proposals could be used - SNFs are subject to a SNF Value-Based Purchasing Program as well as IMPACT Act Quality Reporting Program Measures. CMS should utilize those tools in operationalizing the interrupted stay policy and related monitoring rather than "additional scrutiny"
Page 21064 – Thus, we believe it is necessary and appropriate to include these items in the Swing Bed PPS Assessment beginning October 1, 2019, in conjunction with the proposed implementation of the PDPM. The items we propose to add to the Swing Bed PPS assessment are provided in Table 34. We invite comments on this proposal.	- AHCA supports the addition of the three proposed data elements identified in NPRM Table 34 to the Swing Bed PPS assessment as they will be necessary to help determine the SLP and NTA component case-mix payment rates - AHCA recommends additional items be added to the Swing Bed PPS assessment should CMS adopt the AHCA proposed approach to add additional condition and comorbidity checklist items to Section I of the PPS MDS for determining the PT, OT, SLP, and NTA component case-mix payment rates

General Position Statement

AHCA appreciates CMS' efforts to reduce SNF administrative burden and free up staff time to deliver care. However, as currently proposed, we believe the concepts will increase burden beyond current requirements and complicate day-to-day SNF operations. Below, we offer suggested approaches to mitigate burden and eliminate potential new complexity.

1. *IPA Creates New Burden but Can Be Streamlined with Clearer Guidance on Triggering Events.*

    a. *Alternative Approach to IPA Trigger*

The proposed rule appears to require an IPA when there is a change in at least one of the first-tier classification criteria for any of the components under the proposed PDPM and the change will result in a change in payment, and the changes are such that the resident would not be expected to return to their original clinical status within 14 days. There is some confusion within the provider community about whether the intent is to only require these assessments if there is a **first-tier change,** because the proposed rule goes on to say, "To clarify, the change in classification group described above refers to not only a change in one of the first tier classification criteria in any of the proposed payment components, but also to one that would be sufficient to change payment in either one component or in the overall payment rate …," which

some are interpreting as meaning any change that would cause a change in payment (such as change in ADL score for example) would require an IPA, not just those that relate to first-tier payment items.

Even if it is the intent to limit IPAs to only first-tier related changes in condition, we believe this places significant burden on providers to monitor for numerous changes that affect payment and also exposes providers to significant provider liability risk for failing to complete the IPA. For example, there are 50 conditions and services that would change the payment rate for the NTAS component alone.

The proposed rule requires IPA to be completed no later than 14 days after a change in a resident's first-tier classification criteria is identified. We are also concerned about providers facing penalties for late completion of an IPA because an auditor disagrees with when the change was identified. For example, some first-tier criteria relate to specific diagnosis codes. Often there can be a period of time between the resident first experiencing symptoms and the physician making a diagnosis. It is unclear if the deadline for completion of the Interim Payment Assessment would start with the onset of symptoms or receipt of the physician diagnosis. Because of these concerns, we would like to narrow the definition of when an Interim Payment Assessment would be required.

Recommendations:

- **AHCA proposes that CMS convene a stakeholder group to develop a more narrowly defined set of circumstances that would require completion of an Interim Payment Assessment. For example, perhaps an Interim Payment Assessment should only be required if the resident experiences a change in major category within the nursing component (extensive services, special care high, special care low or clinically complex) or experiences a change in condition or extensive service used for NTA classification that is assigned a score of two or more points.**
- **As part of the above recommendation, AHCA requests clarification to the proposed policy that the intent of the Interim Payment Assessment requirements is to only complete these assessments for first-tier assessment criteria that also results in a change in payment rate.**

These refinements to the Interim Payment Assessment criteria would help reduce provider burden and limit risk of provider liability, while also allowing the proposed payment model to be responsive to major changes in the resident's condition to ensure an appropriate payment rate is available.

b. IPA and Lack of an NTAS Reset is Problematic

As currently proposed, the IPA would not provide for a reset of the variable per-diem adjustment schedule for the associated resident. We appreciate the analysis that some costs decline over the

course of the SNF stay. However, we are concerned certain changes in condition result in the initiation of new and costly NTA services that will be difficult to provide under the proposed payment methodology without a reset of the variable per-diem adjustment. For example, a resident could be newly diagnosed with an infection that requires the use of one of three common and expensive medications:

- Linezolid (used for treatment of gram-positive bacteria resistant to other antibiotics including VRE and MRSA)
- Fidaxomicin (used for treatment of pathogenic Clostridium difficile)
- Posaconazole (used as an anti-fungal for treatment of Candida and other species in immunocompromised patients)

Without the ability to reset the payment methods schedule, this would almost certainly result in financial loss on these patients. As discussed in our payment methods (Section F), we believe the combined effects of the IPA policy and NTAS costs will result in access issues for high-cost patients or patients with highly unpredictable care needs.

Recommendation:

- **CMS has proposed a points system for the NTAS component. To address care needs that emerge mid to late stay for high cost NTAS, AHCA recommends CMS work with stakeholders to develop a threshold of additional NTAS points that would allow providers to reset the NTAS variable per-diem to Day One. The Association envisions the NTAS component resetting to Day One if a patient's NTAS score increases by a possible two or more points. The Association would welcome the opportunity to work with CMS in identifying the appropriate threshold.**

2. *AHCA supports a streamlined MDS schedule but believes the admission MDS proposals require modification.*

As stated repeatedly throughout our comments, we see the proposed approach to mandate the submission of fully-specified ICD-10 condition and procedure codes on the MDS to support case-mix assignment for the PT, OT, SLP, and NTA component conditions and comorbidities as the most challenging proposed PDPM feature that requires revision. The proposed policy is excessively burdensome and could lead to patient access, compliance, and program integrity problems totally unrelated to resident need. Based in part on the below discussion, we have offered rational recommendations for alternative MDS condition and comorbidity reporting that would achieve CMS desire to base payments on resident classification rather than resource use.

AHCA has assessed Health Insurance Portability and Accountability Act (HIPAA) requirements for transaction coding. And, as required, SNFs have used ICD diagnosis coding on claims since 2015. CMS has proposed adding ICD-10-CM codes and/or ICD-10-PCS codes for classification

at admission on the MDS. We do not believe ICD-10-CM or ICD-10-PCS coding is part of a "transaction" under HIPPA and, therefore, not required under law. Additionally, we believe such coding creates new burdens and risks for providers.

In terms of compliance with such a requirement, hospitals have described serious challenges with ICD-10-CM and ICD-10-PCS coding. They also have indicated transmittal to SNFs at the point of SNF admission is impossible due to final sign-off by physicians on diagnosis and related coding in the hospital billing offices, which may take weeks. This is one of the key reasons hospitals are not required to submit fully-specified ICD-10 codes upon admission as CMS is proposing for the SNF PDPM. Similarly, physicians report they experienced great difficulty in the transition from ICD-9 to ICD-10. With PDPM, in addition to current claims processing staff, SNFs would be required to train clinicians submitting MDS information become ICD-10 coding experts as well as acclimate to a new payment system when hospitals and physicians, which are more familiar with diagnostic coding, have indicated they struggled with coding alone.

We also believe such coding in SNFs will create serious challenges with coding consistency, accuracy, and will expose SNFs to considerable liability for recovery based on MAC, RAC, or other reviewer payment and audit decisions. Finally, we also note that more time is needed than five to eight days a to capture all patient conditions and related needs. If such a requirement for the admission MDS is maintained, most patients would require an IPA within days of the five to eight admission MDS.

Finally, we note that CMS has not offered a planned approach to transition from RUG-IV to PDPM payments for beneficiaries who have stays that overlap the PDPM implementation date. We request that CMS work with impacted stakeholders to identify the least burdensome approach to transitioning to PDPM per-diem payments during this period.

Recommendations:

- **AHCA has developed an alternative MDS condition and comorbidity reporting approach that would achieve CMS' desire to base payments on resident classification rather than resource use. . See Attachment A to this section.**
- **For the admission MDS timeline, the final admission MDS should have an outer limit of 14 days, meaning the admission MDS could be completed on any days one through 14. SNFs still would be held to the requirement to have an interim plan of care within 48 hours.**
- **As discussed in our Variable Per-Diem section on page XX, we also believe SNFs should be able to modify the admission MDS when new clinical information becomes available from the hospital. We proposed building on the existing modification provision in the RAI Version 3.0 Manual. Such a provision would preclude needless and highly problematic IPAs.**
- **CMS should work with impacted stakeholders to develop a planned approach to address SNF PPS payments for residents admitted to a SNF prior to PDPM implementation, but who are discharged after the PDPM start date.**

3. *Therapy minute monitoring on the discharge MDS is duplicative – claims detail will provide sufficient information.*

CMS proposes to add 18 new therapy service delivery collection items to the SNF PPS Discharge assessment and to require providers to complete these items beginning October 1, 2019, in conjunction with the proposed implementation of the PDPM. Specifically, CMS proposes to add the following items for each therapy discipline (PT, OT, and SLP):

- Therapy Start Date
- Therapy End Date
- Total Individual Minutes
- Total Concurrent Minutes
- Total Group Minutes
- Total Days

CMS' stated rationale is a desire to track and monitor changes in therapy service delivery patterns during the transition from the RUG-IV to PDPM payment model *"to better ensure that residents continue to receive an appropriate amount of therapy commensurate with their needs … as well as to assess compliance with the proposed group and concurrent therapy limit discussed in section V.F of this proposed rule."*

CMS suggests the proposed *"total days"* items for each discipline and mode of therapy would allowing CMS to *"… monitor not just the total minutes of therapy provided to SNF residents under the proposed PDPM, but also assess the daily intensity of therapy provided to SNF residents under the proposed PDPM, as compared to that provided under RUG-IV."*

CMS further states, *"If we discover that the amount of therapy provided to SNF residents does change significantly under the proposed PDPM, if implemented, then we will assess the need for additional policies to ensure that SNF residents continue to receive sufficient and appropriate therapy services consistent with their unique needs and goals."*

AHCA recognizes that inherent in the design of the PDPM case-mix payment model under consideration, which no longer aligns payment with the amount of therapy services delivered, there is a potential that some residents may receive fewer therapy services than under the current RUG-IV payment model. In fact, based on numerous comments from CMS, MedPAC, and other stakeholders, this would be an expected, intended, and desired outcome for certain residents due to the often-stated concerns that the RUG-IV model provides an incentive for therapy services above what may be *"commensurate with their needs."*

However, we also recognize that, as with any significant change in payment models, reasonable efforts to monitor the impacts of the policy change on resident care and outcomes may be appropriate, at least until it is determined that the new payment system is stable and working as intended. We are extremely disappointed that in this section of the NPRM, CMS appears to be

interested in gathering this data only for the purposes of assessing changes in the volume of services and of compliance with proposed limits on concurrent and group therapy modalities. There is no mention by CMS of evaluating the impact of PDPM implementation service delivery changes on CMS-developed quality and outcomes measures commonly associated with effective rehabilitation services.

a. MDS should not be used for monitoring, rather care planning.

AHCA has supported, and continues to support, aligning payment and quality and that the effectiveness of therapy services delivered (e.g., functional outcomes, discharge to home rate, hospital readmissions) should be emphasized more in a payment model than adding administrative processes that restrict care innovation and take time away from direct resident care. Focusing on changes in service delivery patterns without also considering associated outcomes dis-incentivizes value-based care by potentially penalizing or burdening efficient high-quality providers with undeserved administrative scrutiny.

Regarding the proposal to add new therapy start and end date, minutes by modality, and treatment days data elements to the MDS, AHCA strongly believes the MDS should not be used to report data that serves no purpose in determining care plan needs or case-mix payment determination, particularly for information that otherwise is reported and can be audited through other existing CMS mechanisms. AHCA notes that since therapy time is not pertinent to the PDPM case mix payment methodology under consideration, we disagree strongly with counting therapy minutes and days on the MDS in any manner when similar and more robust information can be reported more efficiently via claims submission.

b. CMS Should Build Upon Existing Processes for Part B for Therapy Reporting on Claims Rather than add New Discharge MDS Reporting

AHCA notes that regardless of the payment model, and whether SNF therapy services are furnished by employees or under arrangement, PT, OT, and SLP clinicians will continue to be required to document treatment interventions, including modality and time, to support the medical necessity of the services. In addition, SNF therapy services must gather and report detailed information on claims on a line-item, date-of-service basis for Medicare Part B therapy services as well as for other payers.

As such, electronic health records (EHR) and clinical billing systems are commonly designed to gather therapy-related billing information on a date-of-service basis to populate claim forms via automated processes versus manual entry. We also note that SNF Part A payment policy already includes a requirement for reporting therapy services by revenue center; however, the current information required would be insufficient to meet CMS' PDPM purposes. We propose instead of adding the burden of additional MDS items, that CMS just refine the claims processing instructions, which can leverage existing billing software processes, to provide the more detailed information desired for PDPM. In addition, auditable information related to therapy time is available via administrative cost-report and payroll-based-journal (PBJ) data.

Recommendations:

We recommend the following alternative solution to the CMS proposal to report therapy services via MDS upon the implementation of PDPM (if adopted):

- Under PDPM, SNFs would report therapy service delivery using existing or new claim billing codes
    - The number of 15-minute units of therapy service can be reported on a line-item, date-of-service basis in the PT, OT, and SLP revenue centers (042X, 043X, and 044X respectively)
    - Separate non-payable codes would be used to report individual, concurrent, or group therapy
    - For example, PT, OT, and SLP revenue codes already exist and could be repurposed as follows:
        - 0420 – Physical therapy – general charge (could be repurposed as individual per-15-minutes)
        - 0423 – Physical therapy – group rate (could be reported as per 15 minutes)
        - 0424 – Physical therapy – evaluation or re-evaluation
        - 0429 – Physical therapy – other (could be repurposed as concurrent per 15-minutes)
        - 0430 – Occupational therapy – general charge (could be repurposed as individual per-15-minutes)
        - 0433 – Occupational therapy – group rate (could be reported as per 15 minutes)
        - 0434 – Occupational therapy – evaluation or re-evaluation
        - 0439 – Occupational therapy – other (could be repurposed as concurrent per 15-minutes)
        - 0440 – Speech language pathology – general charge (could be repurposed as individual per-15-minutes)
        - 0443 – Speech language pathology – group rate (could be reported as per 15 minutes)
        - 0444 – Speech language pathology – evaluation or re-evaluation
        - 0449 – Speech language pathology – other (could be repurposed as concurrent per 15-minutes)

- CMS could consider applying a code modifier to identify when the services are under a maintenance plan of care (see Section 3, Subsection D for related *Jimmo* settlement maintenance therapy comments)
- The eight-minute rule used for Part B therapy reporting would be adapted/applied to reconcile which revenue center code is used (individual, concurrent, or group) to assure that individual units reported per day do not exceed total treatment time (see Medicare Claims Processing Manual, Chapter 5, Section 20.2.C).
- The updated coding instructions for PDPM would be described in the Medicare Claims Processing Manual, Chapter 6, Section 30.2.

Advantages of AHCA's proposed claim reporting option versus the CMS NPRM proposal.

- The AHCA proposal will not add administrative burden to MDS coordinators who collect and enter data on 18 new MDS data elements on the SNF PPS discharge assessment as the CMS proposal does
- The AHCA proposal eliminates the need for therapy start and end dates for each discipline as proposed by CMS because this information would easily be identified on the claims by revenue center date-of-service start and end dates during the stay
- The AHCA proposal provides more robust information than the CMS proposal to track the SNF coverage requirement for the resident receiving daily therapy services (at least five days/week), if the therapy is the skilled service qualifying the resident for the SNF stay. The CMS proposal would not permit such assessment.
- The AHCA proposal provides more robust information than the CMS proposal to track therapy evaluations, re-evaluations, and transitions to and from maintenance therapy. The CMS proposal would not permit such assessment, although such information could be useful for quality and PDPM recalibration purposes.
- Compliance with the concurrent and group therapy policies described in section V.F of this NPRM would be easier to monitor for providers and CMS throughout the stay, rather than the CMS proposed MDS non-fatal edit in the QIES ASAP system, which would only trigger after the stay has ended

However, we caution strongly that monitoring of thresholds should only be conducted in the context of the stay, and not per-day or per-week, etc., as resident needs and the ability to participate in these modalities may fluctuate at any given time during the stay. CMS should not apply monitoring in a manner that would micro-manage care delivery and restrict provider flexibility in managing care at any particular point in the stay.

4. *AHCA supports the Interrupted Stay Policy but believes simplification is needed, as well as strategies to address unintended consequences.*

CMS has proposed an interrupted stay policy with parameters addressing re-setting component tapering. If a patient's stay is interrupted for three or fewer days and returns to the same SNF, the re-admission is considered the same stay, no five-day assessment is needed and tapering continues as scheduled for PT/OT and NTAS. However, if a patient is discharged for longer than three days or is discharged from one SNF to a different SNF, the admission is considered a new stay, a five-day assessment is required and all tapering returns to day one.

a. Days are irrelevant, patient condition matters.

CMS explored several ranges of days in its research and determined three days to be the most appropriate. AHCA disagrees with the use of days as the trigger for a five-day assessment. While we appreciate CMS efforts to reduce the number of five-day assessments, SNFs must conduct a patient assessment upon readmission for all patients. Therefore, there is no reduction in burden by not requiring a five-day assessment for patients returning following three or fewer days. Also, AHCA believes not performing a five-day assessment for all returning patients recreates unneeded risk for patients and SNFs. The result of the five-day assessment should determine whether the patient's condition has changes and new care needs are present, not a number of days.

Recommendations and Request for Clarification

- **For all interrupted stays a five-day assessment must be completed. Tapering may or may not restart based upon the patient's condition.**
- **SNFs must have medical documentation to support an IPA restarting tapering at day one. Such medical information would be submitted to the MAC and made available to RAC auditors.**
- **As with new admissions, a modification may be made if new information becomes available from the hospital that impacts classification**
- **CMS does not explicitly discuss discharge to the community and the interrupted stay policy. AHCA requests clarification. However, we note that our proposed five-day for all readmissions would hold true for the community, as well as assuming the qualifying three-day hospital stay requirement has been met.**

b. Use of Interrupted Stays and Assessments may be monitored and addressed without heightened scrutiny.

SNFs already are the most highly regulated and monitored profession in health care. A new policy with additional scrutiny and risk increases provider burden. Already, CMS has programs in place to monitor and penalize SNFs for rehospitalization. The SNF Rehospitalization VPB Program reduces all SNF rates by 2%. SNFs may earn a portion of these funds back by keeping rehospitalization rates low. Also, SNF performance on return to community and related quality measures under the IMPACT Act Quality Reporting Program (QRP) are publicly reported. SNFs who perform poorly on QRP measures are less likely to be included in Medicare Advantage Plan

or Accountable Care Organization provider networks. Heightened scrutiny for poor performance already is in place.

Recommendations:

- **SNF re-admissions to hospitals under the existing program should serve as the monitoring tool**
- **As with the SNF VBP Program, QRP performance also will serve a monitoring tool. Poor performing SNFs will be penalized by the market – no additional government action is needed.**

5. Swing Bed Assessments Need to Include New Items to Permit PDPM Resident Classification

CMS is proposing to add three items to the Swing Bed PPS assessment as listed in NPRM Table 34. These items were not previously included in the Swing Bed PPS assessment because they have not been used for payment. However, the presence of each of these items would be used to classify swing bed residents under SLP and NTA components of the proposed SNF PDPM.

NPRM TABLE 34—PROPOSED ITEMS TO ADD TO SWING BED PPS ASSESSMENT

MDS item No.	Item name	Related PDPM payment component
K0100	Swallowing Disorder	SLP
I4300	Active Diagnoses: Aphasia	SLP
O0100D2	Special Treatments, Procedures, and Programs: Suctioning, While a Resident	NTA

AHCA supports the addition of the three proposed data elements identified in NPRM Table 34 as they will be necessary to help determine the SLP and NTA component case-mix payment rates. However, we believe items will be required to be added to the Swing Bed PPS assessment should CMS adopt our recommendations to apply MDS Section I condition and comorbidity checklists that would apply to the PT, OT, SLP, and NTA components. See our detailed discussion of Section I checklist coding options on PT and OT component, SLP component, and NTA component recommendations comments in Section 3 Subsections E, i, ii, and iv. of our comments.

Recommendations:

- **AHCA supports the addition of the three proposed data elements identified in NPRM Table 34 to the Swing Bed PPS assessment as they will be necessary to help determine the SLP and NTA component case-mix payment rates**
- **AHCA recommends that items be added to the Swing Bed PPS assessment should CMS adopt the AHCA proposed approach to add additional condition and comorbidity checklist items to Section I of the PPS MDS for determining the PT, OT, SLP, and NTA component case-mix payment rates**

Attachment A

AHCA Proposal for MDS Clinical Condition and Comorbidity Checklists as an Alternative Reporting Option to the Proposed PDPM ICD-10-CM and ICD-10-PCS Reporting Methodology

AHCA Proposal

- **AHCA strongly recommends that, as an alternative option to submitting ICD-10-CM and ICD-10 -PCS codes as proposed in the NPRM, CMS could add checklist items to Section I of the SNF PPS admission MDS for providers to report the primary condition for PT, OT, and SLP component classification, and comorbidities and conditions that apply to the SLP and NTA component classification that are not currently captured on the SNF PPS admission MDS.**
    - This recommendation would not preclude providers from entering ICD-10-CM codes into Section I8000 of the MDS (as proposed) that map to any of the PT, OT, SLP or NTA condition or comorbidity groups if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently
    - This recommendation would not change existing ICD-10-CM claim diagnosis reporting requirements that are subject to the submission of fully-specified ICD-10-CM codes per MAC claims-processing and Local Coverage Determination (LCD) coding policies
    - We oppose the proposed use of Section I0020 of the MDS for this purpose as the current I0020 item set was established specifically for the SNF QRP mobility and self-care measures to be implemented on October 1, 2018. We believe the existing I0020 item set is insufficient for determination of the PDPM clinical categories proposed to be used for the PT, OT, and SLP PDPM clinical categories, and any modifications to this item set would corrupt the SNF QRP mobility and self-care outcome measures.
- **The specific descriptive condition and comorbidity checklist items AHCA recommends being added to Section I of the MDS by component are:**
    - ***PDPM Clinical Category (NPRM Table 14, PDPM Calculation Worksheet pp. 5,9,13)***
        - Major Joint Replacement or Spinal Surgery
        - Non-Orthopedic Surgery
        - Acute Neurologic
        - Non-Surgical Orthopedic/Musculoskeletal
        - Orthopedic Surgery (Except Major Joint Other Orthopedic Replacement or Spinal Surgery)
        - Acute Infections
        - Cancer
        - Pulmonary
        - Cardiovascular and Coagulations
        - Other Medical Management
    - ***SLP-Related Comorbidities (NPRM Table 22 & PDPM Calculation Worksheet pp. 14-16)***
        - Laryngeal Cancer

        - Apraxia
        - Dysphagia
        - Progressive Neurologic Diseases
        - Oral Cancers
        - Speech and Language Deficits
    - ***NTA Conditions (NPRM Table 27 & PDPM Calculation Workbook pp. 19-20)***
        - Lung Transplant Status
        - Major Organ Transplant Status, Except Lung
        - Opportunistic Infections
        - Bone/Joint/Muscle Infections/Necrosis – Except: Aseptic Necrosis of Bone
        - Chronic Myeloid Leukemia
        - Endocarditis
        - Immune Disorders
        - End-Stage Liver Disease
        - Narcolepsy and Cataplexy
        - Cystic Fibrosis
        - Specified Hereditary Metabolic/Immune Disorders
        - Morbid Obesity
        - Psoriatic Arthropathy and Systemic Sclerosis
        - Chronic Pancreatitis
        - Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
        - Complications of Specified Implanted Device or Graft
        - Inflammatory Bowel Disease
        - Aseptic Necrosis of Bone
        - Cardio-Respiratory Failure and Shock
        - Myelodysplastic Syndromes and Myelofibrosis
        - Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies
        - Diabetic Retinopathy – Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
        - Severe Skin Burn or Condition
        - Intractable Epilepsy
        - Disorders of Immunity – Except: RxCC97: Immune Disorders
        - Cirrhosis of Liver
        - Respiratory Arrest
        - Pulmonary Fibrosis and Other Chronic Lung Disorders

AHCA Justification

Simplicity

The design of the PDPM had compressed the extensive list of over 65,000 available ICD-10-CM codes into a relatively small and reasonable list of discrete clinical condition and comorbidity groupings that apply to the PT, OT, SLP, and NTA components. ICD-10-PCS codes would be used to further refine the PT and OT case-mix conditions into surgical and nonsurgical classifications.

In our PDPM comments, we highlight concerns regarding the challenges of obtaining sufficient clinical information from hospitals, physicians, and other providers within the very narrow SNF PPS admission assessment timeframe to establish fully-specified and auditable ICD-10 diagnosis and procedure codes on the MDS for multiple conditions and comorbidities applicable to the different PDPM components, including:

- Hospitals do not typically determine final discharge diagnoses until weeks after discharge when the claim is submitted, and usually only share limited interim discharge diagnoses with SNFs
- Hospitals and physicians do not commonly transfer, and may not even have immediately available, sufficiently detailed documentation necessary to transfer to the SNF to permit the SNF to adequately identify fully-specific ICD-10 codes upon SNF admission. This is particularly problematic for ICD-10-PCS codes that may require surgical details, i.e., the type of appliance and whether an adhesive was used for a joint replacement for services not provided in the SNF.
- While a SNF may have interoperable HIT technology, referring providers may not, or they are located in areas with limited high-speed internet capabilities, which would require extensive manual review, scanning, and data entry of medical history and treatment data by the SNF before multiple appropriate fully-specified ICD-10 codes could be identified for the admission MDS.
- In the PDPM Clinical Category Mapping Excel Workbook Tool, 24,114 out of 65,038 (37%) ICD-10-CM codes are identified as return-to-provider (RTP) codes not mapped to PDPM. This could create billing and compliance problems if used. It is unclear if MDS software applications can address this discrepancy.
- CMS and Medicare Administrative Contractor Claim ICD-10 coding guidance and Local Coverage Determination (LCD) policies may not be aligned with the proposed PDPM ICD-10 condition and comorbidity guidance. Additionally, the NPRM does not contain a proposal related to the relationship of the MDS conditions and comorbidities and what from the MDS should be submitted on the claim, if anything.

While such challenges could eventually be overcome with sufficient cross-provider health information technology (HIT), we note that a recent Office of the National Coordinator for Health Information and Technology September 2017 report titled Electronic Health Record Adoption and Interoperability among U.S. Skilled Nursing Facilities in 2016 indicates that a significant portion of SNFs are not in a position to leverage the potential efficiencies of HIT for such purposes.

Despite a lack of government support comparable to that provided to hospitals and physicians, SNFs have been reducing the technology gap (only 31% do not have an EHR or HIO). However, per the ONC report, interoperability remains a huge barrier as *"Nine percent of SNFs reported that their staff was able to easily integrate patient health information from outside sources into their EHR,* ***that is, without scanning or manual entry.*** *However, only 7% of the facilities reported the ability to engage in all four interoperability domains."* These gaps are substantial and justify a judicious and incremental approach to implementing any mandatory technology-dependent components into new MDS reporting requirements.

In the examples below, we note CMS has made an initial important step towards simplicity with nominal impact on payment precision by: 1) using available MDS checklist items that describe conditions that impact the various PDPM case-mix group weights for the SLP-related comorbidities and the NTA-related conditions, and 2) compressing all ICD-10-CM diagnosis codes into 10 discrete PDPM clinical categories, which are further collapsed into four discrete clinical categories for the PT and OT components, and also into two discrete clinical categories for the SLP component. CMS has even proposed the concept of whether it might be easier to report PDPM conditions via an MDS checklist option, and requested feedback on whether MDS Section I0020 could serve that purpose.

We agree that a PDPM MDS condition and comorbidity checklist items would reduce burden on many providers and that such an approach would not violate HIPAA coding requirements. Specifically, AHCA legal counsel has advised us that while the UB-04/CMS-1450 claim forms have been identified as the standardized claim transaction under HIPAA, and therefore require the use of ICD-10 coding when submitted electronically (which SNF's have historically done), the MDS does not meet the electronic standard transaction requirements, meaning the mandatory ICD-10 coding requirements to report conditions and comorbidities do not apply. Therefore, we believe the following AHCA proposal to reduce PDPM condition and comorbidity reporting burden is both reasonable and legal.

AHCA Proposal

We propose that CMS further compress the PDPM condition and comorbidity reporting requirements so the provider has the option to enter all required patient PDPM classification information on the MDS vis descriptive checklists, as an alternative to using fully-described ICD-10-CM or ICD-10-PCS codes. Regardless of the reporting method, the medical record documentation supporting how the MDS items were reported are the same. However, the checklist option reduces significant administrative and compliance burden associated with identifying and justifying fully-described ICD-10-CM or ICD-10-PCS while having no impact on payment accuracy.

Specific to SLP-related comorbidities, we note that Table 9 of the PDPM Calculation Worksheet for SNFs (add link) (see below) indicates six of the 12 SLP-related comorbidities are proposed to be identified by information entered into existing MDS descriptive item fields, and that CMS would not be requiring detailed ICD-10-CM codes for the presence of conditions aphasia; CVA, TIA, or stroke; hemiplegia or hemiparesis; or traumatic brain injury. However, CMS is proposing to require detailed ICD-10-CM codes to be entered for the other six SLP-related comorbidities of Laryngeal Cancer, Apraxia, Dysphagia, ALS, oral cancers, and speech and language deficits (in italics in Table 9 below) into MDS fields in I8000 because there are currently no check-box item fields currently on the MDS to report these conditions.

NPRM Table 9: SLP-Related Comorbidities

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis

I5500	Traumatic Brain Injury
I8000	*Laryngeal Cancer*
I8000	*Apraxia*
I8000	*Dysphagia*
I8000	*ALS*
I8000	*Oral Cancers*
I8000	*Speech and Language Deficits*
O0100E2	Tracheostomy Care While a Resident
O0100F2	Ventilator or Respirator While a Resident

We further note that Table 10 of the PDPM Calculation Worksheet for SNFs lists 53 distinct ICD-10-CM codes for the "oral cancers" condition group, and that the only difference between these codes are related to location of the neoplasm and add no value to the PDPM classification beyond the SNF identifying the person has a condition of an oral cancer. Since the individual ICD-10-CM codes for the SLP-related comorbidities add complexity and reporting burden to SNFs without impacting the SLP component case-mix determination, we recommend CMS instead add the six SLP-related narrative comorbidities categories that are proposed for ICD-10-CM code entry into a PDPM-required SLP-related comorbidities check list added to Section I of the MDS. The MDS manual guidance could describe the clinical documentations that would support whether one of these condition items are checked as present, similar to how other existing MDS items are defined in the MDS manual.

Specifically, we recommend that these six items could be integrated into the existing SNF PPS assessment MDS Section I "Active Diagnoses in the Last 7 Days" checklists (items I0200-I6300), or as a separate PDPM SLP-related comorbidities checklist similar to the current MDS I0020 item set.

This recommendation would not preclude providers from entering ICD-10-CM codes into Section I8000 of the MDS (as proposed) that map to the SLP-related comorbidities if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently. However, we note CMS has not provided any ICD-10-CM mapping for the six of the SLP-related co-morbidities that would use existing MDS items, so providers that elect to submit ICD-10-CMs codes would still be burdened by a need to complete these six MDS items.

Specific to NTA-related comorbidities, we note that Table 12 of the PDPM Calculation Worksheet for SNFs indicates nine of the of the 50 NTA-condition/extensive service comorbidities are proposed to be identified by information entered into existing MDS descriptive item fields, and that CMS would not be requiring detailed ICD-10-CM codes for the presence of conditions major organ transplants, chronic lung diseases, wound infections, diabetes, diabetic foot ulcers, multi-drug resistant organisms, stage 4 pressure ulcers, other foot skin problem (infections/lesions)and malnutrition. However, CMS is proposing to require detailed ICD-10-CM codes to be entered for 28 NTA-related condition comorbidities of MDS fields in I8000, accounting for 1,552 unique ICD-10-CM codes, because there are currently no check-box item fields currently on the MDS to report these conditions.

Like our SLP-related comorbidity comments above, we note the additional code detail beyond the broad narrative category description adds no value to the PDPM classification beyond the SNF identifying that the person has a condition identified in Table 27 of the NPRM. Since the individual ICD-10-CM codes for the NTA-related comorbidities add complexity and reporting burden to SNFs without impacting the NTA component case-mix determination, we recommend CMS instead add the 28 NTA-related narrative conditions categories that are proposed for ICD-10-CM code entry into a PDPM-required NTA-related conditions check list added to Section I of the MDS. For example, a majority of the proposed NTA-related condition coding specificity is related to body regions, tests, procedures, and other details related to inpatient hospital care and billing requirements not readily available to the SNF. We propose the MDS manual guidance could describe the clinical documentations that would support whether one of these condition items are checked as present, similar to how other existing MDS items are defined in the MDS manual.

Specifically, we recommend that these 28 items could be integrated into the existing SNF PPS assessment MDS Section I "Active Diagnoses in the Last 7 Days" checklists (items I0200-I6300), or as a separate PDPM NTA-related conditions checklist similar to the current MDS I0020 item set.

This recommendation would not preclude providers from entering ICD-10-CM codes into Section I8000 of the MDS (as proposed) that map to the NTA-related conditions if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently. However, we note CMS has not provided any ICD-10-CM mapping for the nine of the NTA-related conditions that would use existing MDS items, so providers that elect to submit ICD-10-CMs codes would still be burdened by a need to complete these nine MDS items.

With regard to the case-mix classification groups applicable to the PT and OT components, we note Table 15 of the NPRM (see below) indicates that a mapping of 40,924 of the over 65,000 ICD-10-CM diagnosis and ICD-10-PCS procedure codes are compressed into 10 distinct PDPM clinical categories, and that these categories are further collapsed into the four proposed PT and OT clinical categories. The remaining 24,114 codes (37%) are noted as "Return to Provider."

NPRM TABLE 15: Proposed Collapsed Clinical Categories for PT and OT Classification

PDPM Clinical Category	Collapsed PT and OT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Non-Orthopedic Surgery	Non-Orthopedic Surgery and Acute Neurologic
Acute Neurologic	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic

Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Acute Infections	
Cancer	
Pulmonary	
Cardiovascular and Coagulations	

Feedback from AHCA front-line clinical experts indicate they are extremely concerned that the proposed approach to require entering specific ICD-10-CM and possibly ICD-10-PCS codes is excessively burdensome and potentially unnecessary to report the resident's primary condition necessary for determining the PT and OT component case-mix weights. We note that fully-described coding often includes details of anatomical structures, test results, and procedures furnished in an inpatient hospital basis that are not readily available to the SNF, and many are identified as return-to-provider (RTP) codes that could create billing and compliance problems if used. We believe reporting the descriptive PDPM clinical category(ies) that apply to the resident upon admission, rather than fully-specified ICD-10-CM or ICD-10-PCS codes, does not impact the ability of the SNF to accurately identify an appropriate PDPM clinical category from available documentation.

We propose that CMS provide a 10-item PDPM Clinical Category checklist in section I of the MDS, similar to the current MDS I0020 item set, so the provider has the option to enter all required patient PDPM classification information on the via descriptive checklists, rather than fully-described ICD-10-CM or ICD-10-PCS codes. Regardless of the reporting method, the medical record documentation supporting how the MDS items were reported are the same. However, the checklist option reduces significant administrative and compliance burden associated with identifying and justifying fully-described ICD-10-CM or ICD-10-PCS while having no impact on payment accuracy.

We propose the MDS manual guidance could describe the clinical documentations that would support whether one of these condition items are checked as present, similar to how other existing MDS items are defined in the MDS manual (See example MDS Manual guidance for our Proposed Definition of PDPM 10 Primary Clinical Categories below).

This recommendation would not preclude providers from entering ICD-10-CM and ICD-10-PCS codes into Section I8000 of the MDS (as proposed) that map to the four collapsed PT and OT component clinical categories if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently.

This proposal would remove much of the complexity and burden associated with identifying and mapping tens of thousands of diagnosis codes that could apply to the PDPM PT and OT case-mix

weights. Additionally, the extensive collapsing of the PT and OT conditions into only four discrete primary level case-mix groupings significantly minimizes the risks of classification of the resident into the wrong payment group.

AHCA Example Definition of PDPM 10 Primary Clinical Categories (for MDS Manual)

NOTE: *The below AHCA examples represent a basic framework. We would expect that additional narrative details/examples or exclusions (developed in consultation with providers) would be added to describe broad clinical category or diagnostic sub-groups common to SNF residents to aid the SNF personnel in accurately identifying the applicable PDPM clinical category. For example, we reviewed the CMS mapping documentation for Major Joint Replacement or Spinal Surgery clinical group and identified the most common sub-groups as described in the bullets in the table below (Hip Replacement, Knee Replacement, etc.)*

Example Definition of PDPM 10 Primary Clinical Categories (10 new items)
Major Joint Replacement or Spinal Surgery
During an acute care hospital or CAH hospital within the xx days prior to SNF admission (AHCA suggests 30 days to be consistent with coverage policy that SNF admission must be within 30 days of a hospital or PAC stay), the resident underwent a major joint replacement/reattachment or orthopedic spinal surgery procedure (including spinal cord surgery) to the following structures: • Hip Replacement • Knee Replacement • Ankle Replacement • Lumbar Spine Surgery • Thoracic Spine Surgery • Cervical Spine Surgery • Major joint reattachment (hip, knee, ankle)
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)
During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission, the resident underwent a surgical procedure (including amputation or revision) to any joint or bone not associated with the *"Major Joint Replacement or Spinal Surgery"* PDPM clinical group. Additional sub-group examples may need to be listed.
Acute Neurologic
During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission, the resident received medical and/or surgical treatment for a disorder to the brain, or medical (non-surgical) treatment for a disorder of the spinal cord. Additional sub-group examples may need to be listed.
Non-Orthopedic Surgery
During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission, the resident underwent a surgical procedure not associated with the *"Major Joint Replacement or Spinal Surgery," "Orthopedic Surgery," or "Acute Neurologic"* PDPM clinical groups. Additional sub-group examples may need to be listed.
Non-Surgical Orthopedic/Musculoskeletal

During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission, the resident received non-surgical treatment related to bone, muscle, or connective tissues (e.g. cartilage, ligaments, tendons). Additional sub-group examples may need to be listed.
Acute Infections
During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission, the resident received non-surgical treatment related to an acute infection. Additional sub-group examples may need to be listed.
Pulmonary
During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission, the resident received non-surgical treatment related to a pulmonary condition. Additional sub-group examples may need to be listed.
Cardiovascular and Coagulations
During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission, the resident received non-surgical treatment related to cardiovascular or blood clotting conditions. Additional sub-group examples may need to be listed.
Cancer
During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission. the resident received non-surgical treatment related to cancer. Additional sub-group examples may need to be listed.
Medical Management
During an acute care hospital or CAH hospital stay within the xx days prior to SNF admission, the resident received non-surgical treatment related any condition not included in the above listed PDPM clinical categories. Additional sub-group examples may need to be listed.

AHCA Example Determination of PDPM 10 Primary Clinical Categories (For MDS Manual)

The SNF would answer the following questions in sequence and check all boxes in a new MDS Section I sub-section that apply to the resident. The PDPM grouper would select the clinical category with the highest CMI for the PT and OT case-mix groups and apply the "Acute Neurologic" results to the SLP case-mix determination logic when applicable.

AHCA Example MDS Questions for determination of PDPM Primary Clinical Categories (For MDS Manual)

During an acute care hospital or CAH hospital within the 30 days prior to SNF admission did the resident:

1. Undergo a major joint replacement to any of the following structures (Hip, Knee, Ankle) or undergo surgery to spine (Lumbar, Thoracic, Cervical) or to the spinal cord?
    a. If yes, check the "Major Joint Replacement or Spinal Surgery" PDPM clinical category box

2. Undergo a surgical procedure (including amputation) to any joint or bone not associated with the "Major Joint Replacement or Spinal Surgery" PDPM clinical category?
    a. If yes, check the "Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery" PDPM clinical category box
3. Receive medical and/or surgical treatment for a disorder to the brain, or medical (non-surgical) treatment for a disorder of the spinal cord?
    a. If yes, check the "Acute Neurologic" PDPM clinical category box
4. Undergo a surgical procedure not associated with the "Major Joint Replacement or Spinal Surgery," "Orthopedic Surgery," or "Acute Neurologic" PDPM clinical groups?
    a. If yes, check the "Non-Orthopedic Surgery" PDPM clinical category box
5. Receive non-surgical treatment related to bone, muscle, or connective tissues (e.g., cartilage, ligaments, tendons)?
    a. If yes, check the "Non-Surgical Orthopedic/Musculoskeletal" PDPM clinical category box
6. Receive non-surgical treatment related to an acute infection?
    a. If yes, check the "Acute Infections" PDPM clinical category box
7. Receive non-surgical treatment related to a pulmonary condition?
    a. If yes, check the "Pulmonary" PDPM clinical category box
8. Receive non-surgical treatment related to a cardiovascular or blood clotting conditions?
    a. If yes, check the "Cardiovascular and Coagulations" PDPM clinical category box
9. Receive non-surgical treatment related to cancer?
    a. If yes, check the "Cancer" PDPM clinical category box
10. Receive non-surgical treatment related to any condition not included in the above listed PDPM clinical categories?
    a. If yes, check the "Medical Management" PDPM clinical category box

With regard to the case-mix classification groups applicable to the SLP component, we refer to our comments and proposed solutions above related to the proposed PT and OT component mapping of the over 65,000 ICD-10-CM diagnosis and ICD-10-PCS procedure codes compressed into 10 distinct PDPM clinical categories. However, unlike the PT and OT component where CMS proposes to collapse the 10 condition groups into four discrete clinical categories for case-mix weighting purposes, CMS proposes to collapse all SLP conditions even further into those that are Acute Neurologic as opposed to those that are Non-Neurologic (NPRM pp. 21050-20151).

For SLP clinical category classification under PDPM, we propose CMS also utilize the 10-item PDPM Clinical Category checklist in section I of the MDS, which we describe above in our PT and OT component comments, so the provider has the option to enter all required patient PDPM classification information on the via descriptive checklists, rather than fully-described ICD-10-CM or ICD-10-PCS codes for identical reasons (see PT and OT component comments above). However, in the case of SLP, the 10 PDPM clinical categories would be collapsed into only two SLP clinical categories, Acute Neurologic and Non-Neurologic, for case-mix determination purposes.

This recommendation would not preclude providers from entering ICD-10-CM and ICD-10-PCS codes into Section I8000 of the MDS (as proposed) that map to the four collapsed SLP component clinical categories if they have the health information technology and interoperability capabilities that would permit this to be accomplished efficiently.

This proposal would remove much of the complexity and burden associated with identifying and mapping tens of thousands of diagnosis codes that could apply to the PDPM SLP case-mix weights. Additionally, the extensive collapsing of the SLP conditions into only two discrete primary level case-mix groupings nearly eliminates the risks of classification of the resident into the wrong payment group.

Regarding Section I0020 of the MDS, we oppose the proposed checklist approach to use MDS Section I0020 of the MDS for the purpose of PDPM PT, OT, and SLP clinical category determination as discussed on page 21044 of the NPRM. The current MDS Section I0020 item set was established specifically for the SNF QRP mobility and self-care measures to be implemented on October 1, 2018 (add links to Measure specifications and other similar SNF QRP documentation related to the mobility and self-care measures). We believe the existing MDS Section I0020 item set is insufficient for determination of the PDPM clinical categories proposed to be used for the PT, OT, and SLP PDPM clinical categories, and any modifications to this item set would corrupt the SNF QRP mobility and self-care outcome measures.

Subsection H. Group and Concurrent Therapy Proposals

NPRM Comment Request	AHCA Comments
Page 21065-21068 – We invite comments on the proposal discussed above. In addition, we solicit comments on other ways in which therapy limits may be applied to appropriately meet the care needs of SNF residents.	- AHCA recommends CMS consider adopting the separate 25% concurrent therapy and 25% group therapy limits under PDPM as was proposed in last year's RCS-1 ANPRM.
	- As an alternative, AHCA recommends CMS could track the proposed 25% combined limit under PDPM at a facility-level.
	- AHCA supports the CMS proposal for therapy minutes in PDPM to be reported by unallocated patient time receiving therapy services (rather than therapist time allocated across residents) regardless of individual, concurrent, or group therapy delivery modes.
	- AHCA recommends CMS redefine group therapy under PDPM to be consistent with the Inpatient Rehabilitation Facility (IRF) definition of two to six residents.
	- AHCA recommends CMS review and revise the therapy minute policies associated with therapy student SNF internships so SNFs are not dis-incentivized from participating in these workforce-development programs under PDPM.
	- AHCA opposes the proposed concurrent and group therapy threshold MDS-driven compliance mechanism under PDPM, and we propose an alternative claim- and quality-driven approach.

General Position Statement

AHCA appreciates CMS' recognition of the clinical value of concurrent and group therapy delivery modalities, and that resident time receiving therapy is the appropriate mechanism for any therapy service delivery tracking method. However, we believe the proposed policies associated with the delivery of concurrent and group therapy are burdensome, inhibit care innovation, and do not focus compliance mechanisms on patient-centered outcomes. Below we offer detailed comments related to the proposed therapy provision policies and our recommended alternative solutions.

1. *CMS Proposal*

CMS proposes that if the PDPM were adopted, then concurrent and group therapy combined should be limited to no more than 25% of a SNF resident's therapy minutes by PT, OT, or SLP discipline.

CMS proposes to achieve this by utilizing the total unallocated number of minutes by therapy mode reported on the MDS to determine compliance with the proposed limit. CMS justifies this approach by stating that concurrent and group therapy have therapeutic value *"… we recognize that, in very specific clinical situations, group or concurrent therapy may be the more appropriate mode of therapy provision and, therefore, we would want to allow providers the flexibility to be able to utilize these modes."* CMS indicates they believe the proposed limits are sufficient*, "… based on the data presented in Table 36, the proposed limit on group and concurrent therapy affords a significantly greater degree of flexibility on therapy modality than appears to be required to meet the needs of SNF residents, given that less than one percent of therapy currently being delivered is either group or concurrent therapy. Therefore, a combined limit of 25 percent for group and concurrent therapy should provide SNFs with more than enough flexibility with respect to therapy mode to meet the care needs of their residents."*
CMS invites comments on this proposal. CMS also solicited comments on *"… other ways in which therapy limits may be applied to appropriately meet the care needs of SNF residents."*

2. AHCA Comments

AHCA agrees with CMS that person-centered care, including therapy services, commonly requires individualized 1:1 care, particularly for residents with advanced cognitive deficits or multiple complexities. However, high-quality outcomes can also be achieved in group or concurrent delivery models with certain residents.
We also agree with CMS' proposal in this NPRM to restore the definition of attributing therapy minutes to reflect the policy CMS had in place from FY 1999 until restrictions were implemented in FY 2011 and FY 2012. Specifically, the current CMS proposal to report and count the resident's time in therapy, rather than the therapists allocated time, is consistent with what we requested in our comments in response to last year's RCS-1 ANPRM comments. We believe that reporting patient treatment time is consistent with the principles of patient-centered care, clinical practice, and clinical research approaches and should be recorded as such in the clinical record and reported on claims.

However, we disagree with the CMS implication that clinical decisions to use individual, concurrent, or group therapy modalities are principally driven by *"… financial considerations rather than on the clinical needs of SNF residents."*

- Our first point is the data in Table 36 of the NPRM demonstrates that prior to the CMS intervention that severely restricted the use of concurrent and group therapy services, slightly more than one-quarter of the <u>average</u> resident's treatment time was delivered using these modalities. Some received more and some less. This demonstrates SNF providers did not historically apply these modalities

indiscriminately, and most of treatment time was individual therapy, even when there was much more flexibility permitted.

- Second, since the restrictions were placed on the ability of SNFs to furnish concurrent and group therapy modalities, CMS has been unable to demonstrate any dramatic changes in clinical outcomes since FY 2011 and FY 2012 that suggest inadequate therapy services were being furnished and the *"clinical needs of SNF residents"* were not being met prior to implementing the restrictions. This demonstrates that regardless of the payment policy restrictions, SNFs have and continue to furnish the therapy services the resident needs. Resident treatment time did not decrease with the CMS payment policy changes in FY 2011 and FY 2012 as CMS anticipated because the resident's needs dictated the amount of therapy. The only change was that the provider cost of delivering care increased.
- We believe the CMS proposal to restore how minutes are reported for concurrent and group therapy modalities, to the policy present before FY 2011 and FY 2012 so the actual time a resident receives therapy will be reported, will remove a barrier that restricted a SNFs ability to furnish these modalities.

We also disagree with the CMS proposal to restrict the total resident treatment time permitted to be delivered by concurrent or group therapy modalities to 25% combined per resident. This proposed limit is not supported by the data and CMS's own statements.

- First, CMS stated in last year's RCS-1 ANPRM, and repeatedly in this NPRM that *"... individual therapy should represent the majority of the therapy services received,"* and *"To help ensure that SNF residents would receive the majority of therapy services on an individual basis,"* and *"We believe that individual therapy is usually the best mode of therapy provision as it permits the greatest degree of interaction between the resident and therapist, and should therefore represent, at a minimum, the majority of therapy provided to an SNF resident."* While these statements are not supported by any available clinical research or professional clinical practice guidelines, they at least are consistent in that CMS believes an individual resident may be better served with at least half of his or her treatment time being provided on an individual basis. However, the proposed PDPM policy is not consistent with these statements and would instead mandate that at least 75% of SNF therapy services be furnished on an individual basis for each resident, regardless of clinical need or potential benefit of concurrent or group therapy.

- Second, the data in Table 36 of the NPRM demonstrates that prior to the CMS implementation of restrictions on the ability to furnish concurrent and group therapy in FY 2011 and FY 2012, the average amount of concurrent and group therapy that was furnished to all residents combined was about 26%. This means there were many residents who received higher amounts and others who received lower amounts based on their clinical status and need. As we mentioned above, CMS has not produced any evidence the quality of care changed dramatically

since FY 2011 and FY 2012, which suggests the quality of care furnished in FY 2010 and earlier was meeting individual resident needs. However, the proposed PDPM policy of mandating at least 75% individualized therapy for all resident's regardless of clinical need would potentially restrict a provider's ability to effectively manage a resident's care needs for those conditions effectively treated with greater than 25% concurrent or group therapy in FY 2010 and in prior years. It is disingenuous for CMS to justify the arbitrary 25% threshold as adequate based upon current utilization patterns as the current policies are dictated by the restrictions imposed in FY 2011 and FY 2012. The appropriate baseline to evaluate any potential threshold should be the service delivery patterns of FY 2010 and prior years.

We propose an alternative approach that could address the CMS concerns about assuring the majority of care is furnished in an individual basis would be to consider adopting the separate 25% concurrent therapy and 25% group therapy limits under PDPM as was proposed in last year's RCS-1 ANPRM, or as an alternative, to track the 25% combined limit at a facility-level (average across all residents) rather than an individual resident level. In such cases, CMS monitoring efforts should target SNFs that have higher rates of concurrent or group therapy and rate lower compared to peers in quality and outcomes measures. It makes no clinical or policy sense to impose administrative and audit burdens on providers that are developing innovative and efficient care delivery models that achieve favorable clinical outcomes just because they are surpassing an arbitrary threshold that does not impact payment rates.

We also note page 20166 of the NPRM, CMS indicates that to manipulate the RUG-IV case mix rates to better reflect provider therapy costs for group therapy, CMS made changes to the definition of group therapy in FY 2012, so instead of defining a group as two or more residents, CMS changed the definition to be *"… exactly four residents who are performing the same or similar therapy activities.* This restriction on care delivery is not consistent with standards of clinical practice or CMS policy that applies to SNF Medicare Part B therapy or other Medicare post-acute provider (PAC) setting policies such as Inpatient Rehabilitation Facilities (IRF). For example:

- Under Medicare Part B outpatient therapy payment policy, which applies to SNF residents who have exhausted or are otherwise ineligible for Part A benefits (e.g., no qualifying three-day hospital stay), the billing procedure code 97150 for group therapy services is defined as "Therapeutic procedure(s), group (2 or more individuals)."
- Under the IRF Part A therapy reporting guidelines, CMS defines group therapy as "Group Therapy: The provision of therapy services by one licensed or certified therapist (or licensed therapy assistant, under the appropriate direction of a licensed or certified therapist) treating two to six patients at the same time who are performing the same or similar activities."

An important fact we must emphasize is over half of the 15,000 SNFs nationwide admit fewer than eight Medicare Part A residents per month, particularly those in rural

locations. In such locations, it is virtually impossible to have groups of exactly four residents performing the same or similar activities at the same time. However, it is much more likely to find that two or three residents might be present who would benefit from the social and other benefits of group therapy, including PT balance programs and OT kitchen, housekeeping, and other activities of daily living (ADL) functional restoration or maintenance programs. Also, in larger and specialized SNFs, there is the potential that there may be up to six residents with similar needs (e.g., post-surgical orthopedic) who would benefit from innovative group therapy programs without negatively impacting outcomes.

We believe CMS should be consistent in applying a definition of group therapy within Medicare and across PAC Part A payment policy that would permit a smoother transition to a unified PAC payment system as envisioned by the IMPACT Act of 2014. As such AHCA recommends CMS redefine group therapy under PDPM to be consistent with the Inpatient Rehabilitation Facility (IRF) group therapy definition of two to six residents at the same time who are performing the same or similar activities.

Another issue related to therapy provision policies not addressed in this NPRM, but should be resolved if PDPM is adopted, is how therapy minutes are to be reported when furnished by therapy students during their clinical internships.

In addition to adopting more stringent definitions of concurrent and group therapy services in FY 2011 and FY 2012, CMS also adopted more stringent policies related to the reporting of therapy minutes when such services were furnished under the supervision of the SNF therapy clinician. For example, CMS policy currently dictates that in cases where the therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy, these services are always coded as concurrent therapy. Under such restrictive guidance, it would be virtually impossible for residents treated by a student or the therapist under the supervision of a therapy clinician to stay below the proposed 25% concurrent or group therapy threshold unless all student/supervisor treatments are delivered as co-treatments. Such scenarios undermine the student experience and development of clinical competence, and is counterproductive to the expectation of therapy schools that the student demonstrate increased independence during their clinical experience. Since FY 2011, this has and could continue to jeopardize the ability of therapy schools to train a competent workforce as an increasing number of SNFs may be reluctant to accept student internships that could put them at risk for increased CMS monitoring and interventions under PDPM. We note Congress is currently considering legislation to address the severe shortage of health care professionals specializing in geriatric care, and we believe CMS policy should also be sensitive to such needs. AHCA recommends CMS review and revise the therapy minute policies associated with therapy student SNF internships so SNFs are not dis-incentivized from participating in these workforce-development programs.

Finally, CMS proposes a vaguely defined concept for tracking the percentage of concurrent and group therapy on a per-stay, per-resident, and per-discipline basis that is

being described as a proposed compliance mechanism. We believe the proposed approach would add provider burden, would dis-incentivize the development of innovative approaches to care delivery that reduces Medicare costs while improving quality, and does not include mechanisms to avoid inappropriately targeting providers that are leading innovation while obtaining positive clinical outcomes (i.e., those providers MedPAC refers to as "efficient providers" – further defined as "those facilities identified as providing relatively high-quality care at relatively low costs"). AHCA opposes the proposed concurrent and group therapy threshold MDS-driven compliance mechanism, and we propose an alternative claim- and quality-driven driven approach. We discuss this alternative approach in more extensive detail in our comments related to Section V.E.3 of this NPRM (see Section 3 Subsection G.3).

Proposed Solutions:

- **AHCA recommends CMS consider adopting the separate 25% concurrent therapy and 25% group therapy limits under PDPM as was proposed in last year's RCS-1 ANPRM**
- **As an alternative, AHCA recommends CMS could track the proposed 25% combined limit under PDPM at a facility level**
- **AHCA recommends CMS redefine group therapy under PDPM to be consistent with the Inpatient Rehabilitation Facility (IRF) definition of two to six residents**
- **AHCA recommends CMS review and revise the therapy minute policies associated with therapy student SNF internships so SNFs are not dis-incentivized from participating in these workforce-development programs under PDPM**
- **AHCA opposes the proposed concurrent and group therapy threshold MDS-driven compliance mechanism under PDPM, and we propose an alternative claim- and quality-driven driven approach**

Subsection I. HIV, Provider Behavior, Medicaid, and Implementation Considerations

In the section below, we have combined our responses to several CMS requests for comment because we believe they are interrelated.

CMS Request for Comment	AHCA Responses In-Brief
Page 21073 – We believe that when taken collectively, these adjustments under the proposed PDPM would appropriately serve to justify issuing the certification prescribed under section 511(a) of the MMA effective with the proposed conversion to the PDPM on October 1, 2019, thus permitting the MMA's existing, temporary AIDS add-on to be replaced by a permanent adjustment in the case mix (as proposed under the PDPM) that appropriately compensates for the increased costs associated with these residents. We invite comments on this proposal.	• AHCA has found significant decreases in reimbursement care delivered to persons with HIV • The Association believes CMS' proposed PDPM changes will result in significant access issues • AHCA opposes certification under section 511(a) of the MMA that the PDPM policy appropriately compensates for the increased costs associated with HIV/AIDS residents.
Page 21073 – Accordingly, we specifically invite comments on possible ways to help mitigate any potential disruption stemming from the proposed replacement of the special add-on payment with the permanent case-mix adjustments for SNF residents with AIDS under the proposed PDPM.	• AHCA requests that as part of its broader PDPM Implementation Work Group request that appropriate funding for HIV services be addressed • Funds for such services will have to come from other components or case-mix groups – SNF Stakeholders should make such decisions with CMS
Page 21074 – We invite comments on our assumptions that behavior would remain unchanged under the proposed PDPM and that changes in state Medicaid programs resulting from PDPM implementation would not have a notable impact on payments for Medicare-covered SNF stays. We also invite comment on the impact of these policy proposals on state Medicaid programs.	• AHCA believes provider behavior will change due to PDPM • There are incentives to admit more patients who are medically complex • However, there are exceptions to this observation as discussed in the HIV comments, above • The Association also believes state Medicaid program behavioral changes in response to PDPM could result increased Medicare spending
Page 21079 – With regard to the proposed changes to the SNF PPS discussed in section V of this proposed rule, we provide an accounting of our reasons for each of the proposed policies throughout the subsections in section V and invite comments on any of those proposed changes. In this section, we discuss alternatives considered which relate generally to implementation of the proposed changes discussed in section V, most notably the implementation of the proposed PDPM.	• AHCA recognizes CMS' observation that a blended rate implementation gradually shifting away from RUGs to PDPM is too complex for providers, CMS, and its contractors • However, we believe several steps are necessary: ○ By Fall 2018, form an ongoing PDPM Work Group composed of SNF PPS Stakeholders to

CMS Request for Comment	AHCA Responses In-Brief
	provide meaningful input on implementation efforts o By Fall 2018, convene a technical expert panel on MDS and related assessment changes and alterations o By Fall 2018 convene regular meetings with IT vendors and SNF providers o NOTE: The latter two could be subcommittees for the broader PDPM Work Group.

General Position Statement
*AHCA believes CMS' PDPM research and payment system design **will impact** provider behavior, in particular payment policy changes for patients with HIV, and create challenges among state Medicaid agencies. The Association asserts both will impact implementation planning. Because we believe these three topics are interrelated, we provide comments on provider behavior, state impacts, and implementation in a single section.*

1. ***Provider Behavior Will Change with a Number of Unintended Consequences***

CMS designed PDPM with three goals. We have organized our provider behavior comment by CMS payment model goal. CMS' goals articulated in the Advanced Notice of Proposed Rulemaking are:

- **Payment Accuracy:** ***"****To create a model that accurately compensates SNFs accurately based on the complexity of the particular beneficiaries they serve and the resources necessary in caring for those beneficiaries*
- **Therapy Utilization Concerns:** ***"****To address our concerns, along with those of OIG and MedPAC, about current incentives for SNFs to deliver therapy to beneficiaries based on financial considerations, rather than the most effective course of treatment for beneficiaries*
- **Simplicity:** ***"****To maintain simplicity by, to the extent possible, limiting the number and type of elements we use to determine case-mix, as well as limiting the number of assessments necessary under the payment system"*

Below we discuss the Association's views on potential provider behavior in response to each of the SNF Payment Model Research Project goals.

a. *SNF admission of high-cost, medically complex patients is dependent upon CMS' **payment accuracy** and adequacy to deliver care to such patients*

For years both RUG-IV critics and the SNF profession have expressed concern about RUG-IV reimbursement for nursing and NTAS that are critical to care for medically complex patients. If CMS has appropriately constructed the nursing and NTAS base rates, tapering in the case of NTAS, case-mix indices, and case-mix groups (CMG), we would expect providers to admit more medically complex patients under PDPM than under RUG-IV. However, we believe several elements raise questions about CMS accuracy, which raises questions about achieving the goal of admitting more medically complex patients. And, we believe CMS has created a dis-incentive to admit patients with HIV.

1. *PDPM Will Require Notable Recalibration Due to Use of MS-DRGs in PDPM Research and Design*

To develop the PDPM case-mix model, CMS used the 2016 Standard Analytic File (SAF) data for two purposes: 1) to utilize the MS-DRG data to develop clinical categories for proposed payment groups and 2) to predict clinical conditions that represent NTAS costs per day. In each case, the data and the statistical methods CMS used are questionable. First, the MS-DRGs from the inpatient hospital or the rehabilitation impairment categories (RICS) from the inpatient rehabilitation facility (IRF) that immediately precede the SNF stay were classified into clinical categories. These clinical categories were further aggregated into categories representing different proposed payment groups. For each payment group an independent payment model was developed.

We have concerns about the use of MS-DRGs as the basis for SNF clinical categories. It is well documented that the MS-DRGs do not accurately predict the costs of post-acute care. In its proposed rule, "Advancing Care Coordination Through Episode Payment Models," CMS indicates use of MS-DRGs do not lend themselves to a "number of medical conditions" for purposes of care planning over the course of an episode of care. Specifically, the agency states:

> *"Many non-procedural hospitalizations of Medicare beneficiaries are ultimately categorized based on the principle ICD-CM diagnosis code reported on a claim, which in turn is mapped to a Major Diagnostic Category (MDC) based on the involved organ system, which then leads to the assignment of any of various specific MS-DRGs based on the medical groups in the MDC. … This makes it challenging for providers to engage in care delivery redesign targeted to a specific patient population identified by MS-DRGs. Additionally, it is possible that beneficiaries hospitalized for certain medical conditions also may follow common clinical pathways before and after discharge for which similar care redesign strategies could be developed and used despite those beneficiaries' assignments to different MS–DRGs for their anchor hospitalizations. Thus, we believe that hospitalization for most medical*

conditions would require special consideration in the development of potential future episode payment models that goes beyond CMS' current approach of relying upon the MS–DRG for the anchor hospitalization to begin an episode and identify historical episodes for setting episode prices (81 Fed. Reg. 42,148, 42, 50811)."

While the discussion, above, is in the context of episode design, the point is the same – MS-DRGs are not good predictors across a period of care as patient conditions change and care needs change.

When caring for patients, SNFs must manage high levels, and often unpredictable levels, of resource utilization over longer periods of time relative to short hospital stays due to progressive diseases, comorbidities, or any other medical complication. In studying the reasons for SNF care, AHCA researchers determined the reason the patient is referred to the SNF is not usually directly related to the reasons for hospitalization, which have generally been resolved at the time of discharge. Rather, SNF referral is made because of complex co-morbid conditions that continue and require specialized care via hospital extension services. SNFs continue to provide skilled nursing care (i.e., IV therapy) and rehabilitation services to facilitate recovery and return to function. ***Recommendation:*** *CMS should have a short-term and long-term recalibration plan (see Section 3, Subsection J).*

2. *One Year of Simulation is Insufficient to Predict PDPM Stability*

The Association also is concerned about the use of one year of data for the PDPM simulation. CMS' model freezes payment relativities and classification to a single year and does not reflect current care or allow for future innovations in care delivery. We also believe there are a number of design flaws in the payment system (see Peer Review Statistical Critique, Section 3, Subsection A which result in a misalignment in the research-based distribution of patient classifications and real-world distributions once the system is operational. Stated another way, we believe providers and beneficiaries will struggle with inappropriate classifications. The resulting unintended case-mix will result in access issues, quality of care challenges, and new risks for providers, including compliance issues with the Requirements of Participation and billing accuracy issues.

Finally, as we have noted both in our NTAS Component and Variable Payment comments, we are concerned about NTAS tapering and the proposed Interim Payment Assessment (IPA) policy that would not allow NTAS payments to return to Day One. We believe the lack of NTAS payment flexibility could perpetuate current access issues for high-cost, medically complex patients. ***Recommendation:*** *CMS should run simulations with more years of data and allow NTAS to return to day one when certain point increase thresholds are hit.*

3. Patients with HIV Will Experience Access Challenges.

Reimbursement changes for persons with HIV is discussed in several sections of the NPRM. We believe CMS' proposed changes provide no net improvements from what was proposed in the RCS-1 Advance Notice proposal, will have a significant negative impact on reimbursement for persons with HIV, and consequently will reduce incentives to admit such patients. On page 21076, in the NPRM Impact Analysis – Table 37, CMS notes a 40.5% decrease in payments is expected for HIV/AIDS residents. Although CMS describes attempting to address the payment inadequacies for these patients in this NPRM, the modified approach proposed for PDPM worsens the impact as the payments would be reduced 40.5% as compared to the 40.0% reduction proposed in the RCS-1 model. Such a decrease is untenable and would create significant access issues.

To further demonstrate this point, in one patient example calculated manually using the proposed PDPM policy (see ***Figure 1***), the per-diem payment under RUG-IV throughout the stay would have been $1,295.03 while PDPM payments start at $1,197 during days one to three and then drops precipitously to $689 for days four to 20 and decrease further as PT/OT tapers. This result is after the application of the proposed 18% add-on to the nursing component base rate for these residents included in the PDPM proposal. We obtained similar results using the CMS PDPM Grouper Tool, Version 3, that initially improperly calculated the HIV/AIDS rate and was just recently updated on the CMS website on June 14, 2018.

Figure 1. HIV Case Example

HIV	Urban	RUC	#53									
	Per Diem	CMG	CMI	Total Per Diem Rate by Component								
				1-3	4-20	56-62	84-90					
PT	59.33	TI	1.13	$67.04	$67.04	$59.00	$53.63			Dementia=Medical Management		
OT	55.23	TI	1.17	$64.62	$64.62	$56.86	$51.70			Dementia=Medical Management		
ST	22.15	SD	1.46	$32.34	$32.34	$32.34	$32.34			Dementia= Non Neurologic		
Nursing	103.46	PDE1	1.47	$152.09	$152.09	$152.09	$152.09			Reduced Physical Function		
NTA	78.05	NA	3.25	$760.99	$253.66	$253.66	$253.66			HIV		
Non-case	92.63	NA	NA	$1,077.07	$569.75	$553.95	$543.42					
				$1,169.70	$662.38	$646.58	$636.05					
		Per day		$1,197.08	$689.76			RUG IV with 128% add on				
								1295.03				

Many of these residents are seriously ill and would likely require SNF services for the entire 100-day SNF benefit period, in which their need for high-cost NTA services is not likely to diminish. We do not believe CMS has adequately addressed appropriate payments for HIV/AIDS patients because 1) the proposed payment reductions overall are excessive and will not meet the costs of care and 2) the impact of the proposed NTA tapering policy on HIV/AIDS residents is not sufficiently described to assure us reimbursement will be adequate for residents with such a high-resource-use condition that also likely would require a long stay.

Another concern we have is CMS intends to make this change permanent. On page 21073 of the NPRM CMS states"

"We believe that when taken collectively, these adjustments under the proposed PDPM would appropriately serve to justify issuing the certification prescribed under section 511(a) of the MMA effective with the proposed conversion to the PDPM on October 1, 2019, thus permitting the MMA's existing, temporary AIDS addon to be replaced by a permanent adjustment in the case mix (as proposed under the PDPM) that appropriately compensates for the increased costs associated with these residents.

- **AHCA opposes certification under section 511(a) of the MMA that the PDPM policy appropriately compensates for the increased costs associated with HIV/AIDS residents**

Recommendation: *CMS should work with stakeholders to adjust the CMIs for HIV patients in collaboration with stakeholders. The payment system is budget neutral; therefore, if funding for HIV must come from other sources, such decisions should be made with SNF stakeholder groups.*

b. *It appears the proposed PDPM payment model design is moving in an appropriate direction in addressing cited* ***therapy utilization*** *concerns; however, we are concerned that certain proposed elements of the model intended to protect beneficiaries from changes in therapy delivery sought by the policy change may, in some cases, negatively impact access to PT and OT care for residents with non-orthopedic conditions, and other residents who require SLP care*

Additionally, the proposed therapy delivery compliance policies could stifle the development of innovative care delivery models that improve quality. We understand that by de-coupling therapy services from nursing and NTAS, the PDPM model would eliminate the automatic index-maximization policy that paid the highest nursing and NTA rates for residents receiving the most intensive therapy services, without consideration of the actual intensity of nursing or associated NTAS costs. Such de-coupling would better allocate payments based upon a resident's person-centered resource needs. Additionally, we understand the proposed de-coupling PT, OT, and SLP services into separate components could serve to further improve patient-centered allocation of payments based on resident condition and relative need for a particular type of rehabilitation therapy. We also appreciate the proposal to eliminate the need for burdensome weekly reviews to determine the need for an OMRA therapy assessment as is currently required under RUG-IV.

However, we have the following PDPM design concerns we believe need to be addressed that may otherwise impact provider behavior with unintended consequences on beneficiary access, as well as the ability of providers to develop innovative care delivery models.

1. *The proposed PDPM administrative presumption policy <u>will not permit any resident</u> with a non-orthopedic condition to qualify for administrative presumption of coverage protections from the date of admission through the admission assessment reference date under the PT and OT component administrative presumption policy.*

The bottom line is that under the proposed PDPM policy, regardless of clinical need or functional deficits a resident may have, residents admitted with a non-orthopedic condition will not have the assurance of coverage under PT or OT as they are being assessed, and would be automatically subject to burdensome individual level of care determinations. We believe the proposed blanket exclusion of such protections for these conditions is unfair and creates a systemic and discriminatory bias and disincentive against admitting non-orthopedic residents who may otherwise benefit from PT and/or OT rehabilitation services. Please refer to our extensive comments in Section 3 Subsection K regarding this topic and our recommended alternative solution to protect access to PT and OT services for residents with non-orthopedic conditions.

2. *The proposed PDPM administrative presumption policy <u>will not permit any resident</u> with any SLP needs to qualify for administrative presumption of coverage protections from the date of admission through the admission assessment reference date under the SLP component administrative presumption policy.*

We believe the proposed PDPM policy to totally exclude SLP services in their entirety from the administrative presumption protections is unacceptable. Like our arguments regarding the PT and OT administrative presumption policy concerns stated above, we believe the proposed blanket exclusion of such protections for any SNF SLP need is unfair and creates a systemic and discriminatory bias and disincentive against admitting residents who may otherwise benefit from SLP rehabilitation services. Please refer to our extensive comments in Section 3 Subsection K regarding this topic and our recommended alternative solution to protect access to SLP services for residents with non-orthopedic conditions.

3. *The proposed PDPM therapy utilization compliance mechanisms are arbitrary and do not focus on patient-centered outcomes**.***

CMS has made it clear in the NPRM and in prior public communications that their intent is to implement a policy that would dramatically change the incentives to furnish high amounts of therapy services. As such, we believe CMS expects to see some reductions in the amount of therapy furnished in aggregate, although the degree of reductions based upon condition are uncertain and unpredictable, as patient needs in the SNF setting are variable. CMS also has stated concerns that the process of eliminating the linkage of SNF therapy payments to utilization, and basing payments on resident characteristics, could

provide incentives to swing in a direction that could potentially result in underutilization of therapy services. As a result, CMS had proposed certain policies under PDPM to limit concurrent and group therapy service delivery, to track therapy service delivery to the detail of days and minutes by discipline, as well as proposing new compliance processes.

We believe the proposed therapy utilizations and compliance mechanisms are arbitrary, add unnecessary administrative burden, and could have a chilling effect on the ability of SNFs to establish innovative care design models that reduce costs while improving care. With regard to the delivery of concurrent and group therapy services, we believe the proposed policy that would limit the use of these modalities to no more than 25% of resident time per-resident and per-discipline with definitions established under the RUG-IV payment model are arbitrary and restrictive. We discuss our specific concerns and offer recommended solutions to this issue in Section 3 Subsection H of these comments. We also believe the CMS proposal to track therapy service delivery on the discharge assessment by minute, day, and discipline is also burdensome, and we offer a more reasonable recommended solution to monitor therapy services that would actually provide more meaningful information for providers and CMS in Section 3 Subsection G.3 of these comments.

Finally, regarding the PDPM therapy delivery compliance process, we completely disagree with the proposed approach that focuses entirely on provider concurrent and group utilization patterns without any consideration of the quality of care and outcomes achieved. We believe providers that develop innovative approaches to therapy delivery while achieving good clinical therapy outcomes should not be subject to the additional administrative audits merely because they utilize more concurrent or group therapy than another provider. In Section 3 Subsection G.3 of our comments we offer a recommended solution for a compliance approach that would better define the CMS process of targeting oversight of SNF therapy delivery to focus on quality of care and outcomes changes as PDPM is implemented, rather than solely on the amount of concurrent and group therapy furnished.

*c. While AHCA appreciates CMS' efforts to **simplify** RCS-1, we have ongoing concerns with PDPM complexity.*

While PDPM contains fewer case-mix groups (CMGs) and, like RCS-1, greatly reduces the assessment schedule, a number of complex issues remain that will impact provider behavior. First, AHCA believes it highly unlikely SNFs will be able to complete component CMG assignment accurately within the currently contemplated five-day window. Receipt of medical information from the hospital to support SNF clinician diagnosis assignment to fully-specified ICD-10-CM and ICD-10-PCS codes on the MDS for multiple conditions, procedures, and comorbidities required for PDPM case-mix assignment is highly unlikely. Clinical staff and MDS Coordinator time will be diverted from patient care to secure needed documentation for coding and to ensure accurate

coding. Additionally, the current IPA policy essentially will require ongoing monitoring for the need for an IPA. Such an approach also will require considerable clinician and MDS coordinator time and resources. As with the point, above, we believe these complexities may reduce provider willingness to admit patients with unpredictable and potentially high-cost needs.

Recommendations: *To ensure CMS achieves its goals as they relate to provider behavior, AHCA urges CMS to: a) extend the initial assessment window to an outward boundary of 14 days rather than eight (see Section 3, Subsection G Assessments on page XX), b) allow for modifications to the admission MDS, c)strengthen the proposed administrative presumption policy, d) simplify the proposed therapy compliance policies to align with patient-centered outcomes (see Section 3 Subsection G.3, and e) implement the Association's IPA recommendations (e.g., allow NTAS to return to day one under specific circumstances, etc.); and e) run additional data through the PDPM simulation to determine whether additional refinements to the components and related CMIs, tapering and CMGs might be needed.*

*2. **Medicaid, Third Party Payers, and Alternative Payment Methods***

In response to CMS' requests, above, AHCA has prepared recommendations for state Medicaid agency planning and transition, Medicare non-fee-for-service arrangements, and state survey and certification agencies. Related to these points, we also offer recommendations for PDPM transition and implementation.

a. Medicaid

Many state Medicaid programs will need to also adapt if CMS moves forward with implementing the PDPM payment model in the Medicare program. Many states rely on certain components of the Medicare SNF PPS for establishing case-mix and payment rates for Medicaid beneficiaries. In particular, states that use a Medicaid Case Mix payment system will be impacted.

For states that transition to PDPM:

- There will be less incentive to provide therapy to Medicaid beneficiaries because doing so will not enhance the nursing component of the Medicaid rate as it does under RUG-III and RUG-IV (e.g., some states may still use RUG-III). Under RUG-III and IV, Medicaid patients in rehabilitation categories will have a higher nursing case-mix score than if classified simply based upon their medical and functional needs. This will not be the case under PDPM because, relative to nursing, there are no rehab categories.
- States may see PDPM as an opportunity to reduce Medicaid payment if Medicaid patients, on average, have lower relative nursing scores under PDPM than under RUG-III or IV. States utilize case-mix systems to allocate nursing costs and set

nursing rates based upon the resource needs of the Medicaid patients relative to other payers (Medicare and private pay). If PDPM nursing scores for Medicaid patients are lower relative to those of the other payers, states have an incentive to switch to PDPM and reduce nursing payment to providers. Already, Medicaid payments do not cover nursing facility costs in most states. See MedPAC March 2018 SNF chapter here and page 207. Of note, while many states increased Medicaid rates, the national non-Medicare margin was negative (2.3%) in 2016 down from negative (2.1%) non-Medicare margin in 2015.

- Even if states switch to PDPM, but do not reduce Medicaid nursing payments to providers in the aggregate, there will be a significant redistribution of payments, especially away from providers who were furnishing therapy services to Medicaid patients. The nursing case-mix scores for these patients under PDPM will now be lower than they were under RUG-III or IV. Similar redistributions have occurred, albeit not related to Medicaid patients on therapy, in those states that converted from the RUG-III to RUG-IV grouper. The redistributive impact will likely even be greater with a transition to PDPM due to the likely reduction in nursing case-mix scores for Medicaid patients receiving therapy.

- Additionally, because of the potential PDPM advantages for Medicaid, states may have an incentive to pressure SNFs to discharge long-stay residents under the interrupted stay policy to hospitals. This would allow such long-stay residents to return under a Medicare-financed stay and further reduce Medicaid budgetary pressures. Such pressures could be applied by state survey and certification agencies (see below for more detail on engaging such agencies in a transition and implementation plan).

For states that do not transition to an PDPM, as time measurements and relative weights are updated in the future, it is not clear if CMS will update the RUG-IV grouper algorithm and the crosswalk to RUG-III based upon these updated time measurements. Similarly, if the MDS undergoes changes and refinements, it is not clear if CMS will correspondingly update the RUG grouper as it will for PDPM. AHCA believes it unlikely the Agency will update these resources because CMS will not want to maintain two grouper algorithms, especially if one is considered less accurate than the other in predicting nursing resource requirements. Therefore, we see two significant implications: 1) states will likely need to transition creating the issues noted above or not transition creating complexities for Medicaid and providers, and 2) the result will not only be greater administrative burden on providers but also major payment fluctuation relative to two payers – Medicare and Medicaid. ***Recommendation:*** *CMS, both the Center for Medicare and the Center for Medicaid and CHIP Services (CMCS), should begin education for state Medicaid agencies in the fall of 2018 leveraging the National Association of Medicaid Directors. In many states, payment systems or the authority to submit provider rate State Plan Amendments is in state statute. Therefore, state legislatures must enact legislation to make Medicaid payment system changes. Education for state agency staff must start in the fall of 2018 in order for state agency staff to prepare materials for state legislative sessions, typically January to June.*

b. Medicare Advantage (MA) and Alternative Payment Methods (APM)

Today, approximately 33% of Medicare beneficiaries are enrolled in Medicare Advantage plans, with the remainder in traditional Medicare. Of the remaining 67% in fee-for-service (FFS), 22% are impacted by alternative payment methods (e.g., ACO attribution, the bundling program, and enrollment in Medicare Advantage (MA).[3] This means only 45% of Medicare beneficiaries remain in traditional fee-for-service without utilization and cost controls, including shortened lengths of stay associated with APMs. Additionally, TRICARE uses RUG-IV and likely would transition to PDPM. Because ***half*** of all Medicare beneficiaries are covered by non-traditional Medicare, addition to Medicaid agency liaison, CMS also will need to launch an educational effort for MA plans and APM demonstrations.

For MA, any change to the SNF PPS will result in two possible scenarios: (1) the MA plan might overhaul its payment methodology to mirror PDPM or (2) the MA plan might maintain a RUG-based payment methodology, requiring the SNF to maintain two SNF PPS – Medicare FFS PDPM, and MA RUG-IV.

AHCA believes the latter scenario is more likely. Because CMS is not proposing to test the RCS-1 model prior to broad implementation, we believe most MA plans will maintain a RUGs-based payment methodology, at least in the early stages (i.e., one to two years). As noted above, providers will have to maintain both the RUGs system and the new PDPM system, which will create an administrative burden that CMS has indicated it wishes to avoid in FFS. Additionally, MA plans that pay based on RUGs require providers to perform the same MDS assessments under the same PPS schedule in order to assign patients to a RUG. PDPM changes to the MDS also will require providers to maintain software and training on both versions of the MDS and related schedules.

Recommendation: *CMS should develop a schedule for PDPM education for MA Plans, including but not limited to Medicare Learning Network (MLN) issuances and information in the FY20 MA Advanced Notice and Call Letter. CMS training on PDPM also should be made available via webinars. Direct outreach should also be conducted with plan associations such as AHIP. All of this work must be timed with the MA plan bid submission deadline because which SNF payment system they include in their financial calculations will impact their bids. MA plan bids typically are due in April of each year. CMS also should account for the interaction of current MA plan practices aimed at shortening lengths of stay and, for plans adopting PDPM, PDPM incentives to shorten lengths of stay the reduce utilization levels. The latter could have the unintended consequence of making RoP compliance extremely difficult for SNFs. We also believe addressing this issue is a critical beneficiary protection (see Section 3, Subsection XXX for our beneficiary protections comments).*

[3] Sources: 1. CMS.gov Monthly MA Enrollment File. September 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-State-Items/Monthly-Enrollment-by-State-2017-09.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending 2. CMS.gov Press Release. New Participants Join Several CMS Alternative Payment Models. January 18, 2017. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-01-18.html

The Center for Medicare for Medicaid Innovation (CMMI) operates Accountable Care Organization (ACO) and bundling demonstrations. As noted above, 22% of the 67% of Medicare beneficiaries left in FFS are impacted by these APMs. Both APMs place pressure on SNFs to shorten lengths of stay and, in the case of Model 1 and Model 2 BPCI Classic, reduce costs. And, PDPM introduces payment pressures to shorten lengths of stay, including possible stay scenarios in which SNFs will be paid less than the cost of care. ***Recommendation:*** *Like MA Plans, CMS should develop an equally aggressive PDPM education schedule for ACOs and bundling demonstrations. These should include similar elements – MLN transmittals, education on BPCI target pricing implications, and ACO performance benchmarks. CMS also should account for the interactive effects of payment system pressures to reduce utilization. We also believe addressing this issue is a critical beneficiary protection, as these models often shorten lengths of stay and, therefore, potentially impact patient care (see Section 3, Subsection D). The latter could have the unintended consequence of making RoP compliance extremely difficult for SNFs.*

c. Other State Agencies

Several state agencies in addition to state Medicaid agencies will require education and training. State Survey and Certification Agencies will require education on PDPM, new information on how to perform surveys under PDPM, and training on how to conduct any modified surveys. State LTC Offices of the Ombudsman will require information and training to understand new provider behavior as well as State Units on Aging. Depending upon state government organization, these agencies may or may not be co-located in the same umbrella agency as the Medicaid agency. And, in the case of the LTC Ombudsman, this entity must be independent of state agencies delivering services to older adults. ***Recommendation:*** *Regularly, the Center for Medicaid and CHIP Services (CMCS) convenes a round table meeting of state agency stakeholders. The majority of entities noted above participate in these meetings. AHCA recommends the Center for Medicare request time on the agenda to present on PDPM. In regard to State Survey and Certification Agencies, we would expect the Center for Medicare Chronic Conditions Policy Group to educate the CMS Survey and Certification division. And, in turn, that division of CMS will work with Association of Health Facility Survey Agencies (AHFSA) to disseminate the necessary information.*

3. ***Proposed Implementation***

Above, we have sketched out considerations for provider behavior assessment, state Medicaid agency and other entities, and likely impacts and educational needs. Our key implementation concerns are:

a. ***Additional Simulation to Ensure PDPM Stability Before Implementation.*** On page 21056, CMS notes that for the non-therapy ancillary services (NTAS) component, the Agency used multiple years of

data (FY 2014 to FY 2017) to estimate the impact of comorbidities and extensive services on NTA costs. However, in the provider and beneficiary impact section, on pages 21073 to page 21080, CMS offers no discussion of using multiple years of data. In the PDPM Technical Report, on page 16, Acumen states, "[t]he study window uses data corresponding to stays with admissions in fiscal year (FY) 2017." No year-over-year simulation was run. Running a full simulation using multiple years as with NTAS would have produced a more complete picture of PDPM performance for all components. AHCA believes basing a payment system upon a one-year snapshot of patient characteristics raises serious concerns about PDPM stability.

b. ***Convene Multi-Stakeholder Technical Expert Panel (TEP) Before Implementation in Fall 2018.*** PDPM is the most significant change in SNF payment since the late 1990s. And, today's payment and health care delivery environment is far more complex. As we noted in our May 24 comments, AHCA urges CMS to convene a TEP comprised of National Association of Medicaid Directors and the Association of Health Facility Survey Agencies (AHFSA), referral sources including the American Hospital Association and the American Medical Association, as well as payer representatives – Medicare Advantage Plans, likely from America's Health Insurance Plans (AHIP) and the leading Accountable Care Organization association, National Association of ACOs. Such a broad group is needed to assess implementation timeframes and changes.

c. ***Redesign MDS and IPA Policies Before Finalizing PDPM***. AHCA is deeply concerned about new administrative complexity associated with obtaining support documentation and submitting multiple fully-specified ICD-10 condition and procedure codes on the admission and IPA MDS for case-mix classification, which will dwarf the existing MDS and Other Required Medicare Assessments (OMRA) requirements. AHCA appreciates CMS' efforts to reduce SNF administrative burden by reducing the number of SNF PPS Minimum Data Set (MDS) assessments under PDPM by eliminating the 14-, 30-, 60-, and 90-day assessments and OMRA required under the current payment system. Instead, CMS proposes redesigned and more complex SNF PPS admission and discharge assessments as well as introducing a new PDPM Interim Payment Assessment (IPA) policy, which will require daily monitoring. However, in a real world operating environment, several OBRA-required MDS assessments or elements of such assessments would continue to be required during a resident's Part A stay. Additionally, we believe that as currently proposed, the IPA requirements are more onerous than the current MDS and OMRA schedule. We also respectfully point out that the

PPS Admission MDS alone is already 47 pages long. These proposed changes and the continuation of several current assessments do not support CMS' Patients over Paperwork and related Medicare Simplifying Documentation Requirements. Related to MDS changes, more staff time will be required to ensure required data and clinical information is collected in a timely fashion for the admission MDS, IPA, and MDS discharge assessments, including far more clinical input and scrutiny than under RUGs IV. Finally, we believe more highly skilled administrative staff would be required for PDPM. Attracting and retaining these staff will exacerbate the already highly problematic workforce issue.

d. ***Information Technology Development, Testing and Training***. AHCA understands CMS' commitment to work with IT vendors on software design. Venders have informed AHCA that from the date of final specification receipt to a final product is 12-16 months. After that, SNFs will require considerable training on the new tools to ensure accuracy and ensure accurate transmittal of information to CMS and the MACs. CMS should consider such factors when establishing a realistic PDPM implementation date.

e. ***Claims Processing Change Guidance.*** While the PDPM payment model will be principally driven by changes to MDS coding processes, AHCA expects CMS will change some claim coding requirements as well (e.g., the proposed HIV/AIDS code to obtain the nursing component add-on, how to bill for tapered PT, OT, and NTAS rates, or the AHCA proposed claims therapy service reporting alternative).

f. ***Resident Stays That Overlap PDPM Implementation.*** We note CMS has not offered a planned approach to transition from RUG-IV to PDPM payments for beneficiaries who have stays that overlap the PDPM implementation date. We request CMS work with impacted stakeholders to identify the least-burdensome approach to transitioning to PDPM per-diem payments during this period.

g. ***Early Transition to Therapy Provision Policies Under the SNF PPS.*** On pages 21065-21068 of the NPRM, CMS proposes modifications to policies associated with the delivery of concurrent and group therapy services under the proposed PDPM that would permit more flexibility for SNFs to develop and innovative care delivery models while maintaining or improving the quality of care. AHCA also offers additional suggested modifications in Section 3 Subsection H of these comments. We believe that the disruptions introduced during the transition of PDPM would be

softened by early implementation of finalized changes to the therapy provision policies proposed for PDPM.

Based on CMS' NPRM statements, CMS will implement the payment system on some date certain with no phase-in period. ***Recommendation:*** *AHCA worked closely with CMS on RUGs implementation and would welcome the opportunity to aid CMS with PDPM implementation, which will be impacted significantly by provider behavior changes and state Medicaid agency changes. As with RUGs, we respectfully request CMS convene a PDPM implementation work group that will meet regularly also in fall 2018. CMS will need to develop and disseminate PDPM-related changes to claims-processing guidance. PDPM implementation should also align with realistic CMS and commercial software development and education timeline to mitigate payment disruption risks associated with such a significant change in payment models. CMS should work with impacted stakeholders to develop a planned approach to address SNF PPS payments for residents admitted to a SNF prior to PDPM implementation, but who are discharged after the PDPM start date. Finally, CMS should implement finalized changes the therapy provision policies applicable to PTPM implementation beginning in FY 2019 to ease the transition to the PDPM care delivery model policies associated with concurrent and group therapy delivery.*

Subsection J. Budget Neutrality and Recalibration

CMS Request for Comment	AHCA Response In-Brief

Page 21074 – We invite comments on our proposal discussed above to apply a parity adjustment to the CMIs under the proposed PDPM and to implement the proposed PDPM in a budget neutral manner.	• AHCA believes there are sufficient concerns with PDPM development to question its budget neutrality
	  ○ Use of MS-DRGs in research likely will result in provider underpayments
	  ○ NTAS payments may significantly differ from projections
	  ○ Nursing payments likely are inadequate due to shifts in medical practice
	  ○ Lack of Component Wage Adjustment May Lead to Dropped Services
	• CMS should prepare short-term and long-term recalibration plans to address immediate issues that jeopardize beneficiary access and care, as well as longer term plans to ensure updates to PDPM do not carry over flaws in the underlying research

General Position Statement

AHCA has identified several elements that likely will result in leakage from the PDPM payment system and indicate the system is not budget neutral. This will produce inappropriate reductions as the system is recalibrated. Below we offer more detail.

1. Research Based on MS-DRGs

Payment rates were set and impacts predicted based on using the MS-DRG assignment of the patient as a proxy for clinical status. However, the PDPM when implemented will rely on MDS responses to assign patients to the clinical categories. This mismatch between the model and the implementation could produce unforeseen divergences from the impacts projected in the proposed rule. It will be necessary for CMS to prepare to rapidly analyze the difference between these two approaches to understand whether the model adequately compensates SNF providers. If MDS data reports patients at a net lower acuity level than the predicted clinical categorization, then the budget neutrality assumptions made by the PDPM will be invalid.

2. Alignment of Charges to Costs

In addition, the use of SNF charges may need to be rapidly reevaluated once PDPM is implemented. Because SNF charges have not driven payments under the SNF PPS before, it is possible SNFs will systematically re-evaluate their charges practices to bring them more in line with the cost information within their accounting systems. If SNFs do this, the relationships between a host of variables within the PDPM model may shift. Of

particular concern, high-cost, non-therapy ancillary services may suffer from the same charge compression issues that have been historically documented in the hospital setting. If providers are aware of this challenge and able to revise their charge-masters to alleviate some of the charge compression, the NTA component of PDPM payments may undergo substantial revision when the model is re-run.

3. Section GG Full Implementation Will Result in Shifts

Because MDS Section GG data first became available in 2016, CMS and its contractor were only able to evaluate one year of Section GG scores to build the PDPM. As providers become more familiar with Section GG, administrative practice with regard to completing that section may change. In particular, Section G functional scores operated on an inverse scale to the new Section GG functional score, as well as a different assessment timeframe. Thus, the PDPM may need to be re-run once more stable Section GG data is run, to ensure the PDPM accurately accounts for patient functional characteristics.

4. Component by Component Labor-Share Adjustment are Needed to Ensure Rate Adequacy

While payment rates under PDPM are proposed to be calculated for each of the components, the CMS has proposed to wage adjust only the total payment amount with a single labor-share adjustment calculation. Because CMS has already calculated payment amounts for each component and because cost reports contain all the information necessary to determine the labor share for each component, it would be appropriate for CMS to make separate wage adjustment calculations for each PDPM component. If the components are not individually wage adjusted, fewer services may be delivered than anticipated by the PDPM model. Specifically, providers in low wage areas may encounter cost barriers in the delivery of NTAs, which have virtually no labor cost to provide. Similarly, providers in high wage areas may encounter barriers in the delivery of therapy services, which are nearly all labor-related.

Our analysis of one possible method for calculating labor share suggests the NTA component would have no wage adjustment. The three therapy discipline components would range from 89%-96% labor share. The nursing component would have a labor share of 88%. Finally, we find the non-case-mix component would have a 26% labor share. The wide variation in labor shares for the components is evidence the component-level wage adjustments would be valuable in accurately compensating both high and low wage providers for the exact services they deliver to patients.

When the current PDPM is next re-run to reflect more current data, CMS should ensure all model assumptions are re-evaluated for their validity. Some assumptions may cease to be valid as PDPM influences clinical practice. In addition, variables may become predictive or cease to be predictive of cost once updated data is available. To facilitate transparency when the model is updated, CMS should publish an objective standard for predictive value needed for a variable to be included in the model. As such, it's unknown how and whether future components will stay in the model. In addition, if you want some of these model components to be eligible to be included in the future if their predictive value increases, you should comment on that now.

Subsection K. Administrative Presumption

AHCA appreciates the consideration to update the SNF PPS administrative presumption policy if PDPM is adopted, but we cannot support the proposal without modifications.

NPRM Comment Request	AHCA Comments
Page 21070-21072 – We invite comments on our proposed administrative presumption mechanism under the proposed PDPM.	- AHCA appreciates the consideration to update the SNF PPS administrative presumption policy if PDPM is adopted, but we cannot support the proposal without modifications
	- AHCA Proposes the following modifications to the proposed PDPM administrative presumption policy: o If PDPM is adopted, AHCA recommends the administrative presumption would apply to the following proposed PT and OT case-mix groups: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO o If PDPM is adopted, AHCA recommends the administrative presumption would apply to the following proposed SLP case-mix groups: SC, SE, SF, SH, SI, SJ, SK, and SL

General Position Statement

AHCA strongly agrees 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 PDPM. However, we recommend specific changes to the proposed approach related to the therapy components as described in detail below.

1. *CMS Proposal*

As described on page 21070 of the NPRM, *"the establishment of the SNF PPS did not change Medicare's fundamental requirements for SNF coverage."* These requirements §409.32 include: a physician order for SNF care, the services require the skills of technical or professional nursing and/or PT/OT/SLP personnel, and as a practical matter can only be provided in a SNF on an inpatient basis.

However, as CMS further elaborates, *"… because the case-mix adjustment aspect of the SNF PPS has been based, in part, on the beneficiary's need for skilled nursing care and therapy, we have coordinated claims review procedures with the existing resident assessment process and case-mix classification system. This approach includes an administrative presumption that utilizes a beneficiary's initial classification in one of the upper 52 RUGs of the 66-group RUG-IV system to assist in making certain SNF level of care determinations"* Per CMS, the "administrative presumption" policy under the SNF

PPS means *"... beneficiaries who are correctly assigned one of the designated case-mix classifiers on the initial 5-day, Medicare-required assessment are automatically classified as meeting the SNF level of care definition up to and including the assessment reference date on the 5-day Medicare required assessment."*

In further narrative, CMS describes an intent to continue the application of the "administrative presumption" policy under PDPM but the approach would require some modifications due to the significant change in case-mix methodology transitioning from RUG-IV to PDPM. Unlike the single hierarchical RUG-IV case-mix model in which the most resource-intensive care across all services combined were identified for the administrative presumption policy, the PDPM model separates the nursing, therapy, and non-therapy components, which will require CMS to establish a different process to identify SNF PPS resident admissions that would qualify for the administrative presumption. The CMS proposed solution is as follows:

- The administrative presumption would apply to those residents encompassed by the same nursing categories as are currently designated for this purpose under the existing RUG-IV model:
    - Extensive Services
    - Special Care High
    - Special Care Low
    - Clinically Complex
- The administrative presumption would also apply for those residents who meet the criteria to qualify for the following proposed PT and OT case-mix groups: TB, TC, TD, TF, and TG.
- Finally, the administrative presumption would apply for those resident admissions that meet the criteria the uppermost comorbidity group (11+) under the NTA component.

2. AHCA Comment:

AHCA appreciates the consideration to update the SNF PPS administrative presumption policy if PDPM is adopted, but we cannot support the proposal without modifications.

AHCA strongly agrees 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 PDPM. However, we recommend specific changes to the proposed approach related to the therapy components as described in detail below.

i. Nursing Component

AHCA supports the proposed approach for updating the administrative presumption policy as it would apply to the nursing component. Specifically, AHCA

agrees the continuation of the administrative presumption and the proposed modifications as described for the nursing component makes sense because the approach of using the four identified nursing categories has worked well since the onset of the SNF PPS in 1998. In practice, this would mean the administrative presumption would apply to 17 of the 25 (68%) nursing case-mix groups.

ii. Therapy Components

AHCA agrees the nursing component administrative presumption criteria are insufficient to describe the skilled care needs of those residents who would predictably meet the coverage requirement of daily skilled rehabilitation care, particularly those residents who would require more intensive skilled rehabilitation upon admission without triggering a need for daily skilled nursing care. We agree additional administrative presumption qualification requirements would be needed for these residents if the PDPM model is adopted.

However, we believe the proposed approach to apply the administrative presumption policy to resident characteristics in the proposed PDPM therapy components 1) adds burden and 2) is inherently biased against residents admitted to SNF care with non-orthopedic conditions or comorbidities, and anybody who would require intensive SLP services.

Administrative Burden: We note in the prior AHCA response to the RCS-1 ANPRM, we stated the following:

> *There is no impact analysis provided in the ANPRM or support documents that indicates the volume of SNF residents who would be eligible for the administrative coverage presumption as compared to under the current RUG-IV model. We note the current RUG-IV administrative presumption applies to residents who qualify for a rehabilitation RUG, because those residents are under a plan of care that required skilled therapy services be furnished on a daily basis (at least five days/week) for the ultra-high, very-high, high, and medium RUGs, or at least three days per week of therapy along with daily restorative nursing as per the statutory coverage requirements. Any significant change in the percentage of residents covered, particularly for residents that under RCS-1, if implemented, continue to require daily skilled therapy services, could negatively impact resident access and/or resident liability.*
>
> *AHCA recommends CMS provide an impact analysis identifying and comparing the characteristics of those residents who currently receive the administrative presumption with those who would and would not under the RCS-1 model under consideration to evaluate whether RCS-1 adequately protects residents from access or liability issues.*

We tendered the above recommendation because we were concerned about the potential for increased uncertainty about coverage eligibility upon admission, and the potential

explosion of inappropriate and burdensome audits – something CMS acknowledged in the FY 2000 SNF PPS Final Rule (64 FR 41667).

> *"In addition, we believe that the use of the coverage presumption during these first few days of a resident's stay may provide the additional benefit of enabling medical review resources to be deployed for maximum effectiveness …. This, in turn, will enable medical reviewers to focus their resources elsewhere, on other residents or other portions of the SNF stay that are far more likely to involve the provision of noncovered care."*

Because CMS did not provide an impact analysis in this NPRM on which and how many beneficiaries would no longer qualify for the administrative presumption under the current RUG-IV policy versus the proposed administrative presumption policy, we cannot estimate the additional administrative burden impact of the proposed policy related to increases in the volume of "individual level of care determinations" this policy would generate under PDPM.

Again, we note CMS raised the point in the FY 2000 SNF PPS Final Rule (64 FR 41666) that the administrative presumption policy was introduced specifically to reduce the administrative burden and improve the coverage certainty associated with the first few days of a SNF stay where "individual level of care determinations" were used as follows:

> *Under this system of retrospective review, it was possible for an FI to issue a denial of coverage that was retroactive all the way back to—and even including—the day of SNF admission itself. As noted in the interim final rule, this situation made it extremely difficult for an SNF to predict with any degree of certainty that a particular admission ultimately would, in fact, be covered …. Relative to the situation that existed before the SNF PPS, we believe that this approach provides the SNF with far greater confidence in coverage at the outset of a resident's stay, and enables the SNF, once coverage is established, to continue to bill for the resident's care for as long as the resident's actual care needs continue to support coverage.*

Below we provide specific discussion related to the deficiencies of the proposed approach to identify appropriate qualifiers for the administrative presumption related to SNF therapy services under PDPM, as well as recommendations for rational solutions to avoid the administrative burden and uncertainty issues described above.

PT/OT Components: We note under the proposed PDPM PT and OT component administrative presumption policy, the only criteria being proposed for inclusion is the per-diem case-mix index (CMI) weight, which is arbitrarily proposed to only include the five highest scoring weights, or only 31% of the 16 available case-mix groups. We believe this proposed approach is discriminatory against residents admitted with non-orthopedic conditions, which could result in access issues due to the uncertainty of coverage, as well as the additional administrative burdens of a universal application of "individual level of care determinations" for all non-orthopedic SNF admissions.

For example, a resident admission for a SNF stay subsequent to a stroke for rehabilitation because they could not return home immediately after a hospital stay will not necessarily be eligible for a nursing component administrative presumption, and could never qualify under the PT and OT components as currently proposed. We believe additional criteria must be considered beyond an arbitrarily assigned limit of applying an administrative presumption to only those resident admissions with the five highest PT and OT CMIs.

We propose at a minimum, CMS should apply the PT and OT component administrative presumption using a combination of overall CMI *and* the CMI within each of the four PT and OT component clinical categories that represent the functional levels that reflect the most intensive PT and OT therapy needs for individuals within each PT and OT clinical categories. In our approach, the two most intensive PT and OT functional score CMG within the proposed Medical Management and Non-Orthopedic Surgery clinical category or within the proposed Non-Orthopedic Surgery and Acute Neurologic clinical category, as well as any orthopedic clinical category with a CMG equal or higher than these would qualify for the PT and OT administrative presumption policy (see Table 21 of the NPRM).

Proposed Solution:

- **If PDPM is adopted, we recommend the administrative presumption would apply to the following proposed PT and OT case-mix groups: TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO**

We believe this approach is fair, clinically rational, and would be consistent with the historical CMS intent to target SNF PPS "individual level of care determinations" to those SNF admissions that reflect lower service delivery intensity that are more likely to reveal residents where the §409.31 SNF level of care requirements have not been met. We note our proposed approach, while more flexible than the CMS proposed approach, would still be more restrictive than current RUG-IV policy that automatically deems administrative presumption to all residents who qualify for any RUG-IV rehabilitation group, and as a result, over 90% of SNF admissions currently qualify for the administrative presumption. In our proposed approach, only resident admissions for 11 of the 16, or 69%, of the proposed PT and OT component groups would be eligible for the PT and OT administrative presumption.

SLP Component: We also reject the CMS rationale for excluding a resident admitted with clinical characteristics demonstrating a need for intensive SLP services as a qualifier for the administrative presumption policy. First, the Medicare statute and §409.31 explicitly list SLP services among the professional services that could qualify a resident for SNF services. Second, the argument CMS offers in the NPRM that the SLP component per-diem rates do not taper during the stay is not rational. The proposed PDPM nursing component rates do not taper during the stay either. In the case of the nursing component, CMS has taken the rational approach of assessing the relative intensity of each nursing CMI group (Nursing Component CMIs range from 0.66 to 4.04 – Table 26 of NPRM), and proposes to continue to apply an administrative presumption to resident admissions qualifying for clinical groups with high nursing CMIs. We note the range of proposed SLP component CMI weights in Table 23 of the NPRM (0.68 to 4.19)

reflect a diversity in service intensity even greater than the nursing component. Also, similar to the nursing component, the SLP component applies a range of conditions, comorbidities, and cognition factors that are strong predictors for the need for intensive SNF SLP services (as opposed to PT and OT that only use condition and function variables). For example, under our proposal, a SNF resident admission with evidence of a stroke and swallowing disorder (SLP Group SE) could qualify for an administrative presumption under the SLP component. With the nursing component, CMS has identified 17 of the 25 proposed Nursing component CMI groups (68%) would qualify for the nursing administrative presumption. We are proposing that CMS apply a similar logic to the SLP component and apply the administrative presumption policy to the eight highest intensity of the 12 proposed SLP component CMI groups (67%) as follows:

Proposed Solution:

- **If PDPM is adopted, we recommend the administrative presumption would apply to the following SLP case-mix groups: SC, SE, SF, SH, SI, SJ, SK, and SL**

Like our discussion regarding the PT and OT components above, we believe this approach is fair, clinically rational, and would be consistent with the historical CMS intent to target SNF PPS "individual level of care determinations" to those SNF admissions that reflect lower service delivery intensity that are more likely to reveal residents where the §409.31 SNF level of care requirements have not been met.

iii. NTA Component

As we indicated in our prior comments in response to last year's RCS-1 ANPRM, the concept of attributing an administrative presumption of coverage conditions and treatments that indicate high cost non- therapy ancillary (NTA) use is confusing. The SNF coverage requirements are based on the need for daily skilled nursing and/or skilled therapy care. There is no SNF benefit for NTA coverage per-se. In addition, based on the proposed PDPM NTA point scale (Table 27 of NPRM) and the proposed use of only the highest scoring of the six NTA CMI groups, it is hard to determine whether SNF residents admitted with such a high threshold would not already be qualified for the administrative presumption through the nursing component, which would seem to make this approach superfluous. However, because CMS has not provided an impact analysis that would identify any SNF admissions that may need this NTA component administrative presumption, we do not oppose the adoption of the proposed criteria.

Section 4: Skilled Nursing Facility Quality Reporting Program

NPRM Comment Request	AHCA Comments
Page 21081 – Accounting for Social Risk Factors in the SNF QRP – No comment requested.	- AHCA supports the CMS approach to continue to evaluate how to best account for the effect of social risk factors on the SNF QRP
Page 21081 – Proposed New Measure Removal Factor for Previously Adopted SNF QRP Measures – We are inviting public comment on these proposals.	- AHCA supports the proposed addition of "Factor 8" to the list of factors CMS uses to determine if a quality measure should be eliminated, and the proposal to codify the removal factors
Page 21082 – Quality Measures Currently Adopted for the FY 2020 SNF QRP – No comment requested.	- AHCA requests CMS evaluate several mobility and self-care measures for consideration of opportunities for future revision or elimination of redundancies
Page 21083 – IMPACT Act Implementation Update – No comment requested.	- AHCA appreciates the CMS approach of delayed implementation for the two IMPACT Act domains transfer of health information and care preferences measures until they are ready
Page 21083 – Proposed Changes to the SNF QRP Reconsideration Requirements – CMS is inviting public comments on these proposals.	- AHCA supports the CMS proposal to add MAC email as a third option for providers to receive final decisions, and we request SNFs be notified via at least two of the three options
Page 21084 – Proposed Policies Regarding Public Display for the SNF QRP – CMS is inviting public comments on these proposals.	- AHCA supports the CMS proposal to expand the time frame for calculating the MSPB and the Discharge to Community measures to improve the quality of the data and expand the number of centers with sufficient data for reporting - However, we identify some concerns about the content and timing of public display of the MSPB and mobility and self-care outcomes measures

General Position Statement

AHCA is a strong supporter of the SNF QRP initiative and offers support for several of the proposed future improvements to the SNF QRP program. We also offer comments related to concerns with the content and timing of public display of the MSPB and mobility and self-care outcomes measures.

CMS Proposal

In this section of the NPRM, CMS discusses several proposals for future years of the Skilled Nursing Facility Quality Reporting Program (SNF QRP). No policy changes are proposed to be effective for FY 2019. The SNF QRP is authorized by section 1888(e)(6) of the Act. Under the SNF QRP, CMS reduces by two percentage points the annual market basket percentage update applicable to a SNF for a fiscal year in the case of a

SNF that does not submit required QRP data. Successful SNF QRP data submission and subsequent market basket adjustments are determined annually.

NPRM Subsection VI.B.2.b. Accounting for Social Risk Factors in the SNF QRP – NPRM p. 21081

CMS indicates they continue to explore if and how social risk factors could or should be incorporated into SNF QRP measures, and if so, which ones? CMS is not requesting specific comment, but instead indicate they plan to continue working with ASPE, the public, and other key stakeholders on this important issue to identify policy solutions that achieve the goals of attaining health equity for all beneficiaries and minimizing unintended consequences.

AHCA Comment

As we discussed in our comments in last year's SNF payment rule, AHCA supports CMS' approach to continue to evaluate how to best account for the effect of social risk factors on the SNF QRP. Patients need to be appropriately risk-adjusted based on social determinants of health to ensure that SNFs are not unfairly penalized or rated lower than comparison SNFs, based on the influence of non-clinical social risk factors of patients they are treating rather than the quality of care. It's better to take the time to measure accurately the effect social risk factors have on the SNF QRP than to rush a measure that is not accurate and could create access issues.

NPRM Subsection VI.B.3. Proposed New Measure Removal Factor for Previously Adopted SNF QRP Measures – NPRM p. 21081

CMS proposes to add an additional factor to be considered as part of the criteria for removing previously adopted SNF QRP measures. Specifically, the new "Factor 8" would consider whether the costs associated with a measure outweigh the benefit of its continued use in the program.

AHCA Comment

AHCA supports the proposed addition of "Factor 8" to the list of factors that CMS uses to determine if a quality measure should be eliminated. If Factor 8 is adopted, it should also be codified in regulation. This is consistent with our support of efforts to reduce unnecessary administrative burden.

NPRM Subsection VI.B.4. Quality Measures Currently Adopted for the FY 2020 SNF QRP – NPRM p. 21082

In this section, CMS lists the current 12 measures adopted for the FY 2020 SNF QRP. CMS is not requesting specific comment in this section.

AHCA Comment

AHCA notes five of the 12 SNF QRP measures currently adopted for the FY 2020 SNF QRP are directly related to completion of the MDS Section GG mobility and self-care items with significant item overlap, and question the utility and burden of maintaining multiple measures applicable to the same domains within the SNF QRP. These measures are (extracted from NPRM Table 39):

Application of Functional Assessment/Care Plan	Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631).
Change in Mobility Score	Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634).
Discharge Mobility Score	Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).
Change in Self-Care Score	Application of the IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633).
Discharge Self-Care Score	Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635).

We request CMS evaluate these measures for consideration of opportunities for future revision or elimination of redundancies.

For example, the application of NQF #2631 is a process measure introduced in FY 2017 that is comprised of the 14 MDS Section GG mobility and self-care items available at the time. This measure may be potentially obsolete as CMS is nearly doubling the number of Section GG mobility and self-care items beginning October 2018, while this measure remains unchanged. Additionally, this measure is a process measure, while measures #2633, #2634, #2635, and #2636 are more useful outcomes measures addressing the mobility and self-care domains. As such, we believe #2631 could possibly be proposed for updating or for a Factor 2 or a Factor 8 measure removal reason.
In addition, we note the application of NQF #2634 and #2636 measures use the exact same 15 MDS Section GG items to compare outcomes in the "mobility" domain, while the application of NQF #2633 and #2635 use the exact same seven MDS Section GG items to compare outcomes in the "self-care" domain. We believe there may be burdensome and confusing redundancies with these potentially duplicative measures. We suggest that soon after data collection for these measures begins October 2018, that CMS evaluate whether one of the measures in each domain could be proposed to be removed under the Factor 6 and Factor 8 measure removal criteria.

NPRM Subsection VI.B.5. IMPACT Act Implementation Update – NPRM p. 21083
CMS states they were planning to specify two measures related to the IMPACT Act domains transfer of health information and care preferences in this rule, but are delaying the process at least until next year's rulemaking cycle to conduct further development and testing. CMS is not requesting specific comment in this section.

AHCA Comment
AHCA appreciates the CMS approach of delayed implementation for these measures. This decision is appropriate because the draft measures are evolving as CMS studies them. We note and appreciate the fact that CMS, through the measure development contractors, continue to field test and seek public input on the draft measure specifications. It is better that CMS and their contractors thoroughly assess and refine the quality measures to ensure they are measuring the domain of interest and that they will have a meaningful impact on the quality of care provided and the outcomes of treatment. We support the continued evaluation and testing of these measures prior to adoption.

NPRM Subsection VI.B.7. Proposed Changes to the SNF QRP Reconsideration Requirements – NPRM p. 21083

In this section, CMS explains that the Agency currently notifies providers of SNF QRP non-compliance via 1) the QIES ASAP system or 2) a letter sent through the mail. Additionally, CMS currently notifies providers of final decisions on a request for reconsideration related to the SNF QRP program via 1) the QIES ASAP system or 2) a letter sent through the mail. CMS is proposing to add a third notification option for both processes above by allowing providers to receive the two types of SNF QRP notifications via email from the Medicare Administrative Contractor (MAC). CMS is inviting public comments on these proposals.

AHCA Comment

AHCA supports the CMS proposal to add MAC email as a third option for providers to receive final decisions. AHCA has heard provider complaints about lost mail or the natural delays in notification when sent via postal service, and there are some administrative burdens in accessing the QIES ASAP system to check for notifications. The email option may speed up the notification process as well as reduce some burden. However, notification should not rely on one method. There should be redundancy in messages, so that the center is notified through at least two of the three methods. The letter sent via the USPS should be sent via a method that requires return receipt to ensure the provider received the mail. This is important because letters do get lost in the standard mail and emails can also be blocked for an assortment of reasons that are outside the immediate control of the provider.

NPRM Subsection VI.B.8. Proposed Policies Regarding Public Display for the SNF QRP – NPRM p. 21084

CMS is proposing to change the public display policy for the following two Claims-Based SNF QRP Measures by increasing the number of years to calculate the measures from one to two years:

- Medicare Spend per Beneficiary (MSPB)
- Discharge to Community

CMS justifies this proposed change for the following reasons:

- Increases facilities that MSPB could be displayed publicly from 86% to 95%
- Increases facilities that Discharge to Community displayed from 83% to 94%
- Aligns both measures public display policy with existing IRF and LTCH policy

CMS also proposes to publicly display the following measures in Calendar Year 2020 or as soon as possible:

- Change in Self-Care Score
- Change in Mobility Score
- Discharge Self-Care Score
- Discharge Mobility Score

CMS is proposing these four measures display based on four rolling quarters

- First rolling four-quarter period would reflect January 1, 2019–December 31, 2019 discharges
- SNFs with fewer than 20 eligible cases over the four rolling quarters would have an indicator that the number of cases/resident stays was too small to report.

CMS is inviting public comments on these proposals.

AHCA Comment

AHCA supports the CMS proposal to expand the time frame for calculating the MSPB and the Discharge to Community measures. As CMS noted, increasing the time frame for calculation of the measures will improve the quality of the data and expand the number of centers with sufficient data for reporting. It will also better align these SNF quality measures with other PAC settings.

However, we are concerned about the public display of the MSPB measure. It is unclear now whether CMS yet knows how this measure relates to quality and beneficiary out-of-pocket expenses. Without a linkage between cost and quality, which would be an indicator of value, or at least a very clear plan by CMS to educate consumers, it is uncertain how the public will interpret that data to make health care decisions. We suggest CMS wait until they have a better understanding of the relationship with MSPB and the quality of care, and clearly define the strategy to educate the public on how to interpret the results before making that measure public. We believe any public reporting should include a discussion of beneficiary out-of-pocket costs and not just Medicare expenditures.

Additionally, based on recent experiences and challenges with the initial implementation of SNF assessment-based quality measures, we are concerned that CMS is proposing to publicly report the new mobility and self-care outcomes measure scores using a performance period starting with January 1, 2019 discharges. We note 16 new items are being added to MDS Section GG on October 1, 2018, to permit operation of these new measures. This means SNFs will have little experience with submitting the new data for the new measures before CMS starts using them for publicly reported measures. We also note CMS is proposing the implementation of an entirely different PDPM payment system during the proposed initial four-quarter rolling quarter performance period for these measures, which will stretch the capacities of SNFs to incorporate all the payment model and reporting for the new SNF QRP measures into training and operations at the same time. We suggest CMS consider delaying the public reporting performance period of these four measures at least six months to one year to ensure the quality of the data before using it for public reporting. Furthermore, if CMS adopts the proposed PDPM payment model for October 2019 implementation, then we request the performance period delay be at least one year from the proposed start date.

Section 5: Skilled Nursing Facility Value-Based Purchasing Program

Overarching Comments
AHCA appreciates the careful consideration CMS has put towards ensuring the SNF VBP program is administered fairly for all centers, even those with special considerations such as small SNFRM denominator sizes, newly opened facilities without baseline SNFRM data, those with a high proportion of patients with social risk factor and those affected by extraordinary circumstances outside of their control. We believe that the proposed additions to the program made in the NPRM will ensure that no centers are unfairly harmed by the VBP scoring methodology.

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

C1. Background – *No comments*

C2. Measures

a. Accounting for Social Risk Factors

As in the FY 2018 final rule, CMS again addressed complications related to using social economic status as a risk adjustment variable for the SNFRM measure. CMS will continue to consider research performed by ASPE and the NQF SES trials to inform their decisions as they attempt to address equity and disparities in the VBP program.

AHCA Recommendations:

We encourage CMS to continue to use findings from the NQF Sociodemographic (SDS) trial to inform their efforts to address equity and disparities in the VBP program. Given the currently published research, we do not recommend CMS add SES covariates to the SNFRM risk adjustment model, as we believe this runs the risk of further embedding health disparities by creating biases in reporting, undermining system-based approaches to providing high quality of care, and creating access to care problems.

C3. Proposed Performance Standards

a. Proposed FY 2021 Performance Standards

Due to timing constraints collecting claims data necessary to calculate the SNFRM, CMS could not publish the achievement threshold and benchmark performance standards in the NPRM. The rates, which should not be significantly different than those published in FY 2018, will be available in the final rule.

AHCA Recommendations:

We understand the timing constraints in collecting the MEDPAR file necessary to calculate SNFRM rates for CY 2017. As in our comments for the 2018 NPRM, we reiterate our support to switch performance periods to fiscal years, as opposed to calendar years, so that CMS will have the time required to notify members of

their rates 60 days prior to the start of a fiscal year and release the performance standards in the FY 2020 NPRM.

b. Proposal to Correct Performance Standard Numerical Values in Cases of Errors

CMS proposes a policy to address making changes to performance standards in the event they make a calculation error in SNFRM rates. The proposed policy would update the achievement threshold and benchmark rate should a first error be discovered and would then publicly announce the error and corrected performance standards. Should CMS discover a second error, for the same program year, they would not update the performance standards. While CMS believes a technical error is unlikely, and two errors even more so, they are concerned making more than one change to performance standards in a program year would negatively impact centers improvement efforts by changing the targets of quality improvement.

AHCA Recommendations:

AHCA agrees that making several changes to the performance standards in a program year would be determinantal to improvement efforts as centers are using theses performance standards as quality improvement targets. We support the decision not to update the performance standards more than once in a program year, however, we strongly urge CMS to be transparent if they find additional technical errors and publicly announce these errors.

C4. Proposed FY 2021 Performance Period and Baseline Period and for Subsequent Years

a. Background – No comments.

b. FY 2021 Proposals

For the 2021 VBP program year CMS is proposing the baseline rate be calculated based on the FY 2018 and the performance rate based on the FY 2020.

AHCA Recommendations:

AHCA supports these measurement windows and agrees that a 12-month window is the appropriate time period for calculation of both the SNFRM and eventually the SNFPPR.

c. Proposed Performance Periods and Baseline Periods for Subsequent Program Years

Beginning with the FY 2022 program year and for subsequent program years, CMS proposes to adopt for each program year, a performance period that is the 1-year period following the performance period for the previous program year and a baseline periods that is the 1-year periods following the baseline period of the previous year.

AHCA Recommendations:

AHCA supports these time periods.

C5. SNF VBP Performance Scoring

a. Background – No comments.

b. Proposed Scoring Policy for SNFs Without Sufficient Baseline Period Data

If a center does not have 25 or more admissions from the hospital in a FY contributing to their SNFRM denominator, CMS is proposing that these centers have their VBP score calculated based solely on their achievement score and would not be eligible for an improvement score.

AHCA Recommendations:

AHCA supports this policy and agree that SNFRM rates calculated for centers with less than 25 qualifying admission in the denominator results in a rate that does not reliably represent quality in the center and is susceptible to random variation. We further agree that these centers should have their VBP score based only on the achievement score in the event that their baseline rate is based on a denominator less than 25.

c. Proposed SNF VBP Scoring Adjustment for Low-Volume SNFs

CMS is seeking comment on a policy that would give special consideration to centers with fewer than 25 Medicare FFS admissions in a performance period. Analysis has suggested that centers with SNFRM rates calculated on denominator populations smaller than 25 are not reliable indicators of quality. CMS is proposing these centers be assigned performances scores that would equate to an incentive based payment adjustment of 2%. This would ensure that these low volume SNFs receive their full 2% withhold back.

AHCA Recommendations:

AHCA reiterates the comments made in the 2018 NPRM and strongly support the proposal that returns the full 2% withhold to centers with low denominators. We believe the evidence clearly shows that the SNFRM measure is not a reliable indicator of quality for centers with less than 25 qualifying admissions and these centers should not be subject to the same scoring procedures as other centers. By statue, CMS must return between 50% to 70% of the 2% withhold. CMS ultimately selected 60% in 2018 final rule, we understand this allows for additional funds to be set aside in the program to fund this special low denominator exception and we support allocating these additional funds for the exception.

d. Proposed Extraordinary Circumstances Exception Policy for the SNF VBP Program

CMS is proposing to adopt an extraordinary circumstance exceptions policy intended to allow facilities to receive relief from program requirements due to natural disasters and other circumstances beyond the facilities control.

AHCA Recommendations:

AHCA reiterates its support for this policy.

C6. SNF Value Based Incentive Payments

a. Background – No comments.

Section 6: Interoperability Request for Information

CMS notes on page 21092 that the interoperability section is a Request for Information and is not a formal proposal. The Agency also encourages respondents to provide complete but concise and organized responses. CMS also notes respondents are not required to address every issue or respond to every question.

AHCA agrees and supports this critical line of work, which greatly will enhance patient care as well as Medicare and Medicaid efficiency. And, at AHCA's recent Congressional Briefing, we appreciated Secretary Azar's comments on this topic. Below are the questions most pertinent to AHCA as well as AHCA's responses to questions we believe most germane to the profession. We also offer several possible courses of action to address interoperability challenges unique to long-term and post-acute care relative to acute care providers and settings.

1. CMS notes, "*We have received stakeholder input through recent CMS Listening Sessions on the need to address health IT adoption and interoperability among providers that were not eligible for the Medicare and Medicaid EHR Incentives program, including long-term and post-acute care providers, behavioral health providers, clinical laboratories and social service providers, and we would also welcome specific input on how to encourage adoption of certified health IT and interoperability among these types of providers and suppliers as well*."

While we are supportive of the effort and welcome the opportunity to work with CMS and the U.S. Department of Health and Human Services Office of the National Coordinator, we believe the long-term and post-acute care space requires targeted analysis and planning to fully engage in this effort.

a. SNFs are struggling financially to operate, now, and cannot absorb new requirements.

Due to failure of Medicaid rates to keep pace with costs (i.e., most Medicaid rates do not cover costs) and the collapse of the longstanding Medicare-Medicaid hydraulic, SNFs are struggling to maintain operations. Regarding the latter point, SNFs have long relied on Medicare rates to offset Medicaid payment shortfalls. However, as Medicare Advantage (MA) penetration rates have increased and Alternative Payment Methods (APM) have proliferated, Medicare rates and lengths of stay have eroded. Specifically, 33% of all Medicare beneficiaries now are enrolled in MA plans that pay significantly less than Medicare fee-for-service (FFS). Of the remaining 67%, 22% are impacted by APMs, leaving 45% in traditional FFS without intensive third-party pressures to shorten lengths of stay as well as decrease utilization of higher cost services. While these outcomes are positive for Medicare, beneficiary impacts are mixed and SNF total margins are at an all-time low. See ***Figure 1***, below.

Figure 1. Comparison of Median SNF Medicare Part A Fee-For-Service Margin, Non-Medicare Margin, and Total Margin, 2013-2018

Federal Fiscal Year	SNF Medicare Margin	Non-Medicare Margin	Total Margin
2013	13.1%	-1.9%	1.9%
2014	12.5%	-1.5%	1.9%
2015	12.6%	-2.0%	1.6%
2016	11.4%	-1.5%	1.9%
2017	10.6%	-2.0%	1.6%
2018 (Projected)	9%	-2.3%	0.7%

Source: MedPAC Data Summarized by the American Health Care Association.

Recommendation: *CMS should explore two lines of financial support: a) for Medicaid, the availability for Enhanced FMAP (EFMAP) to states to engage in comprehensive Health Information Exchange (HIE) efforts, which include long-term and post-acute providers. CMS has offered EFMAP to states for a variety of Administration efforts in the past, so precedence exists as well as models for such an approach; and b) Explore MAC-specific demos using CMMI's demonstration authority. CMMI's statutory demonstration authority requires its demonstration projects improve quality and result in program savings. We believe an interoperability demonstration would improve care and produce savings while addressing a serious gap in services.*

b. Long-Term and Post-Acute Care providers cannot access HITECH Act or Anti-Stark Kick-Back Funds.

As you know, Long-Term and Post-Acute Care providers were not included in Meaningful Use; the Anti-Stark Kick-Back provisions did not include our most common partners, hospitals; and very few APMs make use of the telehealth waiver provision. The result is we have virtually no easy approach to address the very serious issue discussed, above. ***Recommendation:*** *CMS should explore with providers strategies for upstream providers to support long-term and post-acute providers with interoperable systems.*

c. *Existing platforms and tools are designed for acute care patients and services*.

Acute care services are designed to address a specific health care issue and are time-limited in nature. For example, a patient enters a hospital, undergoes a surgical procedure, and is discharged. Once discharged to a long-term or post-acute care setting, the patient needs and services are dramatically different: 1) care is focused on longer term recovery, not a short two- to three-day stay; 2) multiple comorbidities and/or degenerative conditions must be managed over the entire course of a longer length of stay; and 3) long-term and post-acute care providers either

are focused upon maintaining function or a return to the highest practicable level of function rather than the completion of a specific procedure or course of treatment.

Additionally, we do not believe there are sufficient existing HIT standards to support interoperable exchange of many of the potential data elements that would be beneficial for hospitals, physicians, or other upstream providers or beneficiaries to transfer to SNF, or vice versa. Our position is supported by information on current gaps specific to SNFs published in a recent Office of the National Coordinator for Health Information and Technology September 2017 report titled *Electronic Health Record Adoption and Interoperability among U.S. Skilled Nursing Facilities in 2016* https://www.healthit.gov/sites/default/files/electronic-health-record-adoption-and-interoperability-among-u.s.-skilled-nursing-facilities-in-2016.pdf. Despite a lack of government support comparable to that provided to hospitals and physicians, SNFs have been reducing the technology gap (only 31% do not have an EHR or HIO). However, per the ONC report, interoperability remains a huge barrier as "Nine percent of SNFs reported that their staff was able to easily integrate patient health information from outside sources into their EHR, that is, without scanning or manual entry. However, only 7% of the facilities reported the ability to engage in all four interoperability domains."

In addition, to meet the mandate of the IMPACT Act, CMS and its quality measure development contractors are struggling to address the domain: *"(E) Accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual, when the individual transitions— ''(i) from a hospital or critical access hospital to another applicable setting, including a PAC provider or the home of the individual; or ''(ii) from a PAC provider to another applicable setting, including a different PAC provider, a hospital, a critical access hospital, or the home of the individual."*

These gaps are substantial and justify judicious and an incremental approach to implementing mandatory SNF interoperability requirements.

Recommendation: *CMS should convene a work group of IT vendors that specialize in long-term and post-acute care provider platforms and providers to design: a) platforms tailored to our populations and services; b) develop a long-term and post-acute care definition of "medically necessary" information; c) develop standardization while allowing for critical local and regional specificity (long-term and post-acute care delivery systems are highly localized relative to more standardized acute care); and d) address alignment with IMPACT Act Quality Reporting Program provisions already in place.*

2. *CMS invites members of the public to submit their ideas on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, as well as how best to further contribute to and advance the MyHealthEData initiative for patients. We are particularly interested in identifying fundamental barriers to interoperability and health information exchange, including those specific barriers that prevent patients from being able to access and control their medical records.*

As we noted above, long-term and post-acute care services are very different from acute care services and our patients' and residents' needs also are different. Most of our patients and residents have: 1) less experience with technology and how to access, manage, and understand their medical records and information; 2) many are unable to undertake such activities due to cognitive impairment – often some form of dementia among older adults or developmental disabilities among persons with disabilities; and 3) due to item two, many patients and residents have a legal guardian or the provider plays such a role. We believe special attention would be required to address HIPAA privacy requirements. Additionally, many older adults prefer paper copies of materials. Education and a glide path to electronic resources likely will need to be designed. ***Recommendation:*** *Similar to the funding effort, a work group or technical expert panel composed of beneficiary groups, clinicians specializing in geriatric care or services to person disabilities, as well as providers should be convened to design an interoperable platform that will meet long-term and post-acute care provider needs, as well as interface with acute care platforms. And, this group also could consider how the IMPACT QRPs could be used as building blocks.*

3. *What types of exceptions, if any, to meeting new or revised interoperability and health information exchange requirements, should be allowed under new or revised CMS CoPs/CfCs/RfPs if they are proposed and finalized in the future? Should exceptions under the QPP including CEHRT hardship or small practices be extended to new requirements? Would extending such exceptions impact the effectiveness of these requirements***?**

a. CMS and AHCA have been working together to remove certain information technology provisions from our Requirements for Participation.

Already, long-term and post-acute care providers, in particular, SNFs, are the most heavily regulated providers in the health care space. Additional administrative requirements would have an array of serious implications. First, such requirements would exacerbate the financial crisis and, because SNFs have Requirements for Participation rather than conditions, many SNFs might be forced to close or withdraw from Medicare. Just at the time when the aging boom is unfolding, this would result in serious access problems. Second, AHCA appreciates CMS' work with AHCA to reduce the Requirements for Participation burden. And, one of the Association's top provisions for elimination is the Facility Assessment (FA). The FA would have required, *"(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations."* Adding such a requirement back would reverse months of work between CMS and AHCA as well as impose an untenable burden on SNFs. **Recommendation:** *CMS should not re-introduce burdensome government regulation oversight but instead turn to more positive incentive-based approaches (see below).*

b. *CMS has promulgated a proposed new payment system for SNFs called the Patient-Driven Payment Model (PDPM).*

PDPM will require several years of information technology transformation to support the new system and provider adaptation. Introducing new interoperability requirements at the same time as PDPM implementation and shake out would create serious operational challenges for IT vendors and providers. ***Recommendation:*** *CMS should not consider implementing interoperability requirements for SNFs, in particular, until the new payment system has been launched and experience has been gained.*

c. CMS should focus on quality outcomes and related incentives to participate in any future interoperability effort and not fall back on government regulation and punitive oversight provisions.

As noted, SNFs already are heavily regulated and subject to an array of government regulations and requirements. At the same time, the IMPACT Act QRPs are in place and could serve as the building block for a quality-based approach to encourage adaptation of interoperability capacity. Specifically, the IMPACT Act transfer of health information measures being developed are contemplating HIE not just between upstream and downstream providers, but also whether patients/families can access or receive health information via portals or other secure electronic means. The current challenge is the SNF IMPACT measures only can be applied to Part A stays while other PAC settings can use IMPACT Act measures for Medicaid, Medicare Advantage, and other payers (see Attachment A for draft specifications for a future MDS item for the draft measures and Attachment B for our comments on these IMPACT Act QRP requirements).

Recommendation: *CMS should consider, once the funding problem has been solved, adding an interoperability QRP or other element at Nursing Home Compare and allow market forces to drive implementation rather than regulation and penalties.*

4. *Will CMS' Data Element Library (DEL) Aid Post-Acute Care Providers*? While DEL was not included in the Interoperability RFI, AHCA felt it important to offer comments because DEL is framed as a resource for post-acute care provider interoperability. AHCA appreciates CMS' work on DEL. Also, AHCA supported the IMPACT Act and supports steps to advance the IMPACT Act. Unfortunately, the Office of the National Coordinator did not work with electronic health record (EHRs) software vendors to design EHRs which support the very different care and characteristics of post-acute care patients. Additionally, while DEL is a helpful library, we face the same challenges as noted above. Post-acute care providers are struggling with razor thin margins making investment in new information technology virtually impossible particularly while they are making mandatory changes needed to comply with Phase 3 of the Requirements for Participation and implementation of a new SNF prospective payment system, the Patient-Driven Payment Model. We would welcome the opportunity to discuss DEL and strategies to make the resource accessible to post-acute care providers via the TEP suggested above.

Attachment A

IMPACT QRP Related Elements

Medication Profile Transferred to Patient: Example of Assessment Items

Q2A At the time of discharge/transfer, did your facility/agency provide the patient's/resident's current medication profile to the patient, family and/or caregiver?	
Enter Code ☐	1. Yes – Current medication profile provided to the patient, family and/or caregiver → Go to Q2B. 2. No – Current medication profile not provided to the patient, family and/or caregiver.

Q2B Indicate the route(s) of transmission of the current medication profile to the patient/family/ caregiver. (Check all that apply)

☐ 1. Electronic Health Record (e.g., electronic access to patient portal)

☐ 2. Health Information Organization

☐ 3. Verbal (e.g., in-person, telephone, video conferencing)

☐ 4. Paper-based (e.g., fax, copies/printouts)