

June 25, 2018

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Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1696-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program (CMS–1696–P)

Dear Administrator Verma:

The American Geriatrics Society (“AGS”) greatly appreciates the opportunity to comment on the Skilled Nursing Facilities (“SNF”) Proposed Rule for Fiscal Year (“FY”) 2019 (CMS–1696-P) [hereinafter, “proposed rule”].¹ The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (“NPPs”) who are devoted to improving the health, independence and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to improve the health, independence, and quality of life of all older people.

The AGS advocates for person-centered care, which is directed to the individual's values and preferences, and involves coordinated care by an interdisciplinary team of professionals. The care should address the comprehensive needs of those with multiple chronic conditions, including medications, behavioral health, and social needs/function.² In reviewing the changes to the case-mix adjustment in the proposed rule, the AGS is concerned that the Centers for Medicare & Medicaid Services (CMS) proposal loses sight of the complex nursing home patient and the importance of person-centered care for the multiple-morbid geriatric patient.

¹ 89 Fed. Reg. 21018, May 8, 2018.

² The American Geriatrics Society Expert Panel on Person-Centered Care. Person-Centered Care: A Definition and Essential Elements. *J Am Geriatr Soc.* 2016;64(1):15-8.

We understand the specific limitations of the current case-mix adjustment system, called the Resource Utilization Groups, Version 4 (RUG-IV), and concerns about utilization patterns, particularly trends in utilization of therapy services, under that system. We appreciate that in this proposal, CMS has attempted to develop an alternative structure that is more refined and avoids classifying patients primarily based on the services provided. However, the AGS is concerned that the new approach, called the Patient-Driven Payment Model (PDPM), still does not properly account for the complexity of patient presentation and therefore could impede the ability of the system to appropriately adjust for differences in case-mix as medical care evolves.

We recommend that CMS adopt the following approaches as it finalizes changes to the case-mix system:

- Incorporate incentives to encourage person-centered care;
- Categorize patients using clinically coherent groupings and avoid combining patients into heterogeneous categories that will limit the ability of the system to recognize changes in utilization over time (for example, we urge CMS to adopt the proposal to separately adjust physical and occupational therapy services to allow for better refinement of these payments as the new case-mix adjustment is implemented);
- Avoid creating incentives to under- or over-utilize specific services, for example, rehabilitation services and mechanically altered diets;
- Adopt proposed revisions to the functional status determination and proceed with a reduction in the number of required assessments of SNF residents.

We describe AGS' concerns in greater detail below as well as provide input on the questions regarding interoperability raised in the proposed rule.

A. Refinements to SNF PPS Should Focus on Improving Incentives to Provide High Quality Care

As noted above, the AGS is a strong advocate for person-centered care and believes that Medicare payment systems should encourage the provision of such care. Ideally, the design of the Medicare payment systems, including the SNF PPS, would incorporate findings on best practices associated with improved patient outcomes and include incentives for providers to adopt those approaches.

We are concerned that the proposed refinements to the case-mix system do not meet this goal or reflect current standards. Under the proposed rule, the PDPM would adjust payments associated with different types of services (physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), nursing services, and non-therapy ancillary (NTA) services) based on patient characteristics found to predict spending in each of those service components. CMS identified the proposed predictors of costs using regression analysis of variables from the Minimum Data Set (MDS) assessment, prior inpatient claims, and SNF claims. In addition, CMS obtained estimates of staff time spent with residents with different characteristics from the Staff Time and Resource Intensity Verification (STRIVE) project conducted in 2006-07. Therefore, the PDPM adjustments are based on historic utilization of services as SNFs have chosen to provide them under the RUG-IV and an extremely dated understanding of staffing needs of SNFs. There is no attempt to identify current best practices or to encourage provision of high quality care. Because the PDPM creates large groupings of patients within the classifications used to adjust the different service components, variation in patient need for particular types of services is not well identified. There is limited effort to differentiate residents for whom the intensity (not just the

volume) of services may be greater, such as residents with impaired cognitive status and or multiple morbidities.

CMS asserts that under the PDPM, the most significant shift in payments would be to redirect payments away from residents who are receiving very high amounts of therapy to residents with more complex clinical needs.³ However, we question the accuracy of this assessment. In our experience, medical complexity increases with the patient's age and the proposed rule also shows that the PDPM would reduce payments for residents older than 75 relative to the current system, with greatest decrease for patients over age 90. It appears that the system may be designed to avoid directing payments based on utilization of therapy services but not necessarily to target resources to the most clinically complex cases.

B. Patients Should Be Classified Based on Clinically Coherent Categories, Not Measures of Historic Service Utilization

We are concerned that the model methodology continues to rely on historic patterns of service utilization to adjust future payments and that following this approach will perpetuate limitations of the current system. The claims being used to model the new system were for stays with admissions in FY 2014 with some additional analysis of FY17 claims,⁴ which means that those claims were paid under the RUG-IV. The primary determinant of case-mix classification under the RUG-IV is the minutes of therapy services received; the more minutes of therapy provided, the more likely the patient would be assigned to a higher paying RUG-IV group. It is difficult to interpret the volume of rehabilitation services in light of limited peer-reviewed research on appropriate volume and best mix of rehabilitation services. However, the Medicare Payment Advisory Commission (MedPAC) has found that the current service mix reflects biases in the design of the SNF PPS⁵ and CMS concurred with their findings, stating in the proposed rule that observed trends in SNF utilization “strongly suggest that providers may be basing service provision on financial reasons rather than resident need.”⁶

It is not surprising therefore to see relatively little variation in the use of therapy services (PT or OT) for patients with very different clinical diagnoses. During the process of developing alternative case-mix models to the RUG-IV, CMS identified ten broad categories of the primary reason for the SNF admission which (Acute Infections, Acute Neurologic, Cancer, Cardiovascular and Coagulations, Medical Management, Non-orthopedic Surgery, Non-surgical orthopedic/musculoskeletal, Major Joint Replacement or Spinal Surgery, Orthopedic Surgery (except Major Joint Replacement or Spinal Surgery)). In an Advanced Notice of Proposed Rulemaking (ANPRM),⁷ CMS indicated that it intended to collapse this list of 10 categories down to five, combining Orthopedic Surgery and Non-Surgical Orthopedic into an “Other Orthopedic” category and combining Acute Infections, Medical Management, Cancer, Pulmonary, and Cardiovascular and Coagulations into a single “Medical Management” category. These groupings are based on similarities in the cost per day for PT and OT services. In the proposed rule, CMS

³ 89 Fed. Reg. 21075, May 8, 2018.

⁴ Acumen, “Skilled Nursing Facility Patient-Driven Payment Model Technical Report”; April 2018, p. 16.

⁵ MedPAC, Report to the Congress: Medicare Payment Policy; March 2017, p. 204.

⁶ 89 Fed. Reg. 21035.

⁷ CMS. Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-Mix Methodology. 82 Fed. Reg. 20980; May 4, 2017.

proposes to further condense the categories by combining the Acute Neurologic and Non-Orthopedic Surgery categories as part of an effort to reduce the complexity of the case-mix adjustment methodology. At the same time, the ANPRM acknowledges that the utilization of therapy services on those claims may be influenced by the opportunity to maximize payment more than by the individual patient's need for the services.

AGS disagrees with this overall approach. CMS should not prioritize simplicity of the case-mix system based on current payment patterns over its ability to more accurately adjust payments to reflect differences in the cost of items and services needed to provide appropriate care to individual patients. As the SNF PPS transitions from utilization-based case-mix adjustments to adjustments based on patient characteristics, clinical distinctions become even more salient. We encourage CMS to develop payment categories based on clinically rational patient groupings rather than classifying patients based on similar cost patterns realized under the current SNF payment model. As noted above, the similarities in relative cost across clinically different groups is likely more reflective of the current reimbursement incentives than of the clinical needs of the individual resident. Grouping patients into expansive categories of principal diagnoses based primarily on similarity in their utilization of PT and OT perpetuates the problems experienced under the current system and limits the ability of the new system to better refine adjustments over time as patients are cared for without the incentives to provide therapy services inherent to the RUG-IV. A more clinically coherent approach will enhance Medicare's ability to align reimbursement with cost as care evolves and readjusts under the new system.

Therefore we recommend that CMS not finalize the proposal to combine the Acute Neurologic and Non-Orthopedic Surgery residents into a single category and to consider separating out diagnoses grouped together into the Medical Management category. Recognizing the constraints of using existing patterns and data, one approach CMS could take to deriving weights for such a system is to conduct a demonstration project or modeling based on best practice assumptions of what care should look like. Alternatively, CMS could look at other settings of care where clinically rational patient groupings are used.

C. CMS Should Monitor the Impact Case-Mix Adjustment May Have on Provision of Therapy Services or Particular Types of Care

We understand why the trends that CMS has observed in utilization of therapy services have prompted the agency to consider the role that the case-mix adjustment system may play in incentivizing provision of those services. However, it is important to remember that before implementation of the RUGS, there were significant concerns that SNF residents were not receiving enough rehabilitation services. The current concerns about overutilization are based solely on increased volume of services over time; CMS has not provided data showing that rehabilitation services are over used relative to an appropriate level of care. While the proposed rule acknowledges stakeholder concerns that residents will not receive needed therapy services under the new case-mix system, CMS does not address how removing the incentives to provide therapy services will improve person-centered care, quality, safety or outcomes.

AGS recommends that CMS evaluate how the observed increase in rehabilitation services may have affected patient outcomes, including return to the community and improvement in activities of daily living (ADLs). For example, some studies have shown that for many patients, the likelihood that the patient will be discharged home is positively correlated with the quantity of therapy received during the

SNF stay.^{8, 9} Should CMS finalize a case-mix system that reduces or eliminates incentives to provide rehabilitation services, CMS should closely monitor the quantity of therapy minutes furnished and the impact that changes in utilization may have on patient outcomes. We also urge CMS to adopt the proposal to separately adjust PT and OT services to allow for better refinement of these payments over time.

In addition, CMS should avoid creating new incentives to adopt certain interventions as a means to increase payments. Under the PDPM, CMS proposed to adjust speech language pathology (SLP) costs based in part on whether or not the resident is receiving a mechanically-altered diet. We recognize that there is limited outcomes data available to determine which clinical categories of patients are most likely to benefit from SLP, however, the AGS believes that the presence of a mechanically altered diet is a poor proxy for such data. We understand that adoption of this element as an adjustment factor was prompted by the assertion by a member of the Technical Expert Panel that SNFs might remove a clinically appropriate diet to uncover or induce a swallowing disorder so that the patient would be classified in a category with a higher case-mix index for SLP services. Such assertion raises serious questions of negligence and should not be the basis for payment policy. If CMS intends to use mechanically altered diet as a basis for adjusting SLP payments, then CMS should lay out the evidence that indicates that mechanically altered diets are in fact more resource intensive than other special nutritional approaches such as personal assistance with feeding.

D. AGS Concur with Other Proposed Refinements from the ANPRM.

While we continue to be concerned about elements of the PDPM, as described above, the AGS appreciates that CMS has made improvements from the model included in the ANPRM. Specifically, we concur with the proposals to include early loss ADLs as well as late loss ADLs when assessing a resident's functional status and to use data from Section GG of the MDS (rather than Section G) to make the functional status determination. Section GG will be utilized in all post-acute care assessment instruments and incorporating this data into the SNF case-mix adjustment will promote consistency with other post-acute payment systems.

In addition we concur with CMS' intent to reduce the frequency of assessments required for patients in a Part A SNF stay. Currently, SNFs are the only post-acute care setting where multiple repeat assessments are required. Reducing the number of assessments will again promote consistency across care settings and will reduce the administrative burden on SNFs.

E. Request for Information on Interoperability

In the proposed rule, CMS states that in light of the widespread adoption of electronic health records (EHRs), particularly among hospitals, CMS is interested in feedback regarding how it can use the

⁸ Jung HY, Trivedi AN, Grabowski DC, Mor V. Does More Therapy in Skilled Nursing Facilities Lead to Better Outcomes in Patients With Hip Fracture? [Phys Ther](#). 2016 Jan;96(1):81-9. doi: 10.2522/ptj.20150090. Epub 2015 Nov 19.

⁹ O'Brien SR, Zhang N. Association between therapy intensity and discharge outcomes in aged medicare skilled nursing facilities admissions. *Archives of Physical Medicine and Rehabilitation* 99.1 (2018): 107-115

Conditions of Participation in Medicare and Medicaid related to health and safety standards to further advance electronic information exchange.

AGS agrees with the need to improve interoperability and would prefer that all EHRs capture the same data as the best means to effectively and consistently share health information among providers. However, reaching that point may require a significant investment of resources to modify existing systems, which presents a challenge for small providers, including SNFs. In the long-term we expect that integrated health systems will need to take the lead in increasing interoperability and CMS should not put broad requirements in the Conditions of Participation that would prematurely burden smaller provider types such as SNFs.

F. Conclusion

AGS appreciates the opportunity to provide CMS with input on proposed changes to the SNF case-mix methodology. We strongly urge that CMS further refine its approach to case-mix adjustment to better incentivize person-centered care. In particular, we ask that CMS adopt the following specific recommendations:

- CMS should not combine Acute Neurologic and Other Orthopedic Surgery into a single clinical category and should consider separating out residents combined in the Medical Management category by clinical condition.
- CMS should address potential impact on patient outcomes of reduction in therapy services.
- CMS should not create a payment incentive to put residents on a mechanically altered diet.
- CMS should adopt proposed refinements including use of early loss ADLs, use of Section GG data to determine patient's functional status, and separately adjusting PT and OT payment.
- CMS should proceed with plan to reduce the number of required assessments.

Thank you for your attention to these comments. Please contact Alanna Goldstein at 212-308-1414 or agoldstein@americangeriatrics.org if you have any questions.

Sincerely,



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President



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