June 26, 2017

FILED ELECTRONICALLY

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1679-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: [CMS-1679-P] Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal to Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020

Dear Ms. Verma:

LeadingAge appreciates the opportunity to comment on the proposed rule, entitled, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal To Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020" (the "Proposed Rule").

The members of LeadingAge and affiliates touch the lives of 4 million individuals, families, employees and volunteers every day. The LeadingAge community (www.LeadingAge.org) includes 6,000 not-for-profit organizations in the United States, 39

state partners, hundreds of businesses, research partners, consumer organizations, foundations and a broad global network of aging services organizations that reach over 30 countries. The work of LeadingAge is focused on advocacy, education, and applied research. LeadingAge promotes home health, hospice, community-based services, adult day service, PACE, senior housing, assisted living residences, continuing care communities, nursing homes as well as technology solutions and person-centered practices that support the overall health and wellbeing of seniors, children, and those with special needs.

SNF PPS Rate Setting Methodology and FY 2018 Update

Rebasing the Market Basket Updates

LeadingAge supports rebasing and revising the SNF market basket from 2010 to 2014. It reflects an improvement for past concerns about the dated nature of the market basket. However, skilled nursing facility (SNF) operations have changed dramatically based on innovations and updates to best practices, a variety of quality initiatives, and increased resident acuity. The shift from volume to value payment methodologies combined with declining fee-for-service (FFS) payment render it critical that FFS compensation be as accurate as possible.

The weights for calculating the market basket update should continue to use the most updated cost data available. The market basket should be rebased and reweighted with greater frequency. Particularly if the SNF wage index continues to directly link to the hospital wage index, rebasing should be on the same schedule as the hospital market basket. Due to the rapidly changing long-term care environment, SNFs have and will

continue to make significant modifications to their operations, including the need to respond to alternative payment models, managed care, and emerging quality requirements. The current assignment of weights within the market basket does not reflect the ongoing shifts in SNF operations or broader marketplace changes.

As a result of the foregoing, LeadingAge strongly recommends the SNF market basket be rebased and reweighted on a more frequent basis than every four years so the type and level of SNF expenditures accurately reflect cost of care. We urge the Centers for Medicare and Medicaid Services (CMS) to update the SNF market basket weights in accordance with the hospital market basket schedule to improve the validity of the SNF market basket methodology and increase the accuracy of the SNF market basket updates.

Wage Index Adjustment

The Proposed Rule cites the mandate under Section 1888(e)(4)(G)(ii) of the Social Security Act requiring CMS to adjust the federal SNF rates to account for differences in area wage levels. Since its inception, CMS has used hospital inpatient wage data as applicable to SNFs. CMS proposes to continue this practice for FY 2018, maintaining "that in the absence of SNF-specific wage data, using the hospital inpatient wage index data is appropriate and reasonable," while also recognizing the apparent distinctions and disparities between these two entities. For example, the SNF Prospective Payment System does not use the occupational mix adjustment of the hospital area wage index, which "serves specifically to define the occupational categories more clearly in a hospital setting" and "excludes any wage data related to SNFs." One example of wage data disparity between SNFs and hospitals would be the failure of the hospital wage index to account for the variation in SNF paraprofessional wages across labor markets, and the overall greater

utilization of certified nurse aides and other paraprofessionals in the SNF setting versus hospitals.

Accordingly, while LeadingAge supports the shift in payment from volume to value as contained in this Proposed Rule, we believe, consistent with Section 315 of the BIPA 2000, the distinctions between SNFs and hospitals should be acknowledged. We recommend that CMS continue to explore potential approaches for collecting SNF-specific wage data and work to establish a SNF wage index.

Other Issues – Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

LeadingAge continues to support beneficiary assessment that is standardized across settings; however, we remain concerned that these measures are not tested at the setting level, and therefore have limited validity for cross-setting comparisons or for public interpretation of how to use this information when comparing various PAC settings.

Social Risk Factors

LeadingAge believes that Social Risk Factors are important considerations for positive outcomes. The World Health Organization http://www.who.int/social_determinants/en/ defines social determinants of health as the conditions in which people are born, grow, live, work and age. An Ad hoc committee of the National Academy of Sciences, Engineering and Medicine http://nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payament-Programs.aspx identified a list of measurable social risk factors for potential use

by Medicare. This committee called for attention to these factors, in both quality measurement and value-based payment systems under Medicare. In particular, dual status was the most strongly associated with poor health outcomes. For the purposes of SNF QRP LeadingAge recommends, at a minimum, that dual eligibility or dual status for Medicare and Medicaid be used as an individual-level risk adjustment to the reported measures. We also recommend the following be considered as individual-based risk factors:

- Education level
- Limited English Proficiency
- Living alone

While many others could be added, we believe this is the core set that strongly affect existing and proposed CMS QRP, such as episode cost, length of stay, functional improvement, return to community and readmissions to the acute hospital. Failure to provide such risk adjustment for these characteristics creates strong disincentives for providers to care for these most vulnerable individuals.

Policy for Retaining SNF QRP measures and Policy for Adopting Changes to SNF QRP measures

LeadingAge maintains that for public reporting and any payment considerations measures must be consistent between reporting cycles. Providers must invest into processes and technology for reporting, and consumers cannot compare changes over time if those very measures differ over time periods.

LeadingAge, however, also recognizes that over time needed corrections and adjustments to measures are required, both to address unintended consequences and to reflect changes in practice or populations. We believe that these changes will involve adequate due process, public comment and CLEAR consumer explanations of when and why measures may change.

SNF QRP Proposed Measures Beginning with FY 2020

- LeadingAge supports the proposed **Changes in Skin-integrity Post-acute Care: Pressure Ulcer/Injury**. However, it is most probable that actual reported numbers of pressure ulcers/injury will change from previous reporting cycles. It will be very important to give clear explanation to consumers why the numbers may appear higher with the new reporting methodology.

- **Proposed Functional Outcome Measures:** While conceptually we support these measures, we are concerned that they are not yet tested in the SNF setting. We are concerned that these measures will be highly dependent on the resident population (e.g., highly functioning short-term rehab versus medically complex or those who either do not have a functional improvement goal or who are already profoundly functionally impaired at admission). We would strongly recommend adequate testing across population types before any public reporting as a means of avoiding any unintended consequences--either in patient selection on admission or consumers' inability to interpret results.

Proposed Functional Outcome Measure Denominator Exclusion

LeadingAge supports the following denominator exclusions:

- *Residents with incomplete stays*
- *Residents with the following medical conditions: coma; persistent vegetative state; complete tetraplegia; locked-in syndrome; severe anoxic brain damage, cerebral edema, or compression of brain*
- *Residents younger than 21 years*
- *Residents discharged to hospice*
- *Residents who are not Medicare Part A beneficiaries*

LeadingAge does not support the exclusion, *Residents who do not receive physical or occupational therapy services.* This exclusion is vague and may, in fact, limit needed physical, speech or occupational therapy evaluation if providers believe they will keep the individual out of the measurement set and improve their reported outcome results. Furthermore, resident treatment plans and goals often change between admission and discharge and would thus create incomplete measurement time periods and outcomes.

Risk Adjustment to Proposed Functional Outcome Measures

In general, LeadingAge supports the proposed risk adjustments, with the addition of dual status, at a minimum, of a social risk factor adjustment. We strongly recommend some testing to ensure these adjustments, in fact, do adjust for meaningful differences in sub-populations and results in valid and interpretable outcome reporting.

Expanding Measure Time Line to Two Years

LeadingAge opposes the expansion of the measure reporting time to two years. IF the intent is to drive quality, 2 year reporting cycles are almost meaningless to drive change or

process improvement. If there is inadequate differentiation in the measures in one-year cycles then perhaps they are not sensitive measures and not should be included.

IMPACT Act Update Proposed Measures

LeadingAge supports the *Brief Interview for Mental Status (BIMS)* and the *Confusion Assessment Method (CAM)* as proposed.

Special Services, Treatments, and Interventions Data

LeadingAge supports the inclusion of these 15 proposed items. LeadingAge, however, does not support the reporting requirement of the 14 –day look back prior to admission. This creates significant burden for reporting and adds nothing to quality reporting.

Other Issues – Skilled Nursing Facility Value-Based Purchase Program (SNF VBP)

LeadingAge supports the implementation of the SNF VBP program as a central step toward improving outcomes for the seniors we serve. We appreciate the additional implementation guidance CMS has provided as part of these proposed rules as well as the opportunity to provide additional feedback on certain key issues.

Value-Based Incentive Pool (VBIP) and Payments

CMS has proposed to only use 60% of the reductions made to SNF payments as part of the SNF VBP program even though the law permits CMS to use up to 70%. We unsurprisingly are disappointed that CMS did not opt to utilize the maximum amount

allowable by law of the withheld dollars for VBIP (70%), as this could have created the opportunity to increase the incentive payments for the top performers. As an advocacy voice for non-profit providers, who invest in staff and typically have higher staffing ratios resulting in positive quality outcomes, we would like to see the greatest percentage of dollars available to reward these top performers, who even according to MedPAC are not enjoying large margins on their Medicare business. By using the 60% of withheld dollars for VBIP, CMS is essentially redistributing the 2% of Medicare FFS rates from the top 60% of SNFs within that group. This approach does not add more dollars to the pot. If instead CMS used the 70% option, it would create a larger pool allowing for larger VBIP to those at the top and greater potential for others to earn back more of the 2% amount that was withheld. In addition, the Medicare Trust Fund will benefit from the reduced hospital spending resulting from the lower readmission rates and as such, does not require CMS to return the additional 10% to the fund.

Based on the foregoing, LeadingAge recommends that CMS use its full authority to utilize 70% of the incentive pool for value-based incentive payments.

Shift from calendar to fiscal year baseline and performance periods in FY 2020

CMS raises three questions as part of this change: (1) Thoughts on the shift from calculating readmission rates based upon calendar year to fiscal year data; (2) Consideration of making further adjustments to the data periods to align with other value-based payment programs for other provider types; and (3) how to handle this transition to fiscal year data usage especially whether it is better to continue to use a full-year of data for the readmission rate calculations or a one-time, three-quarter timeframe?

While LeadingAge supports the shift from a calendar year to a fiscal year baseline and performance period, we agree it poses a unique challenge for the transition year.

As to the CMS question regarding alignment with the hospital value-based initiatives, LeadingAge sees no advantage to aligning with these dates (July 1 – June 30) and believe it would merely cause confusion rather than clarity by adding another set of dates into the mix. Additionally, as patient-level data is not provided currently, we see no enhanced opportunity to improve care across sites of service through this type of alignment. LeadingAge sees no benefit to alignment with the hospital value-based payment initiative and therefore, opposes this change.

Finally, as it relates to the third question of what data to use in for calculating the FY2020 SNF VBP, LeadingAge supports continuing to calculate these rates using a full-year of baseline and performance data as it better accounts for the natural fluctuations of the resident population throughout the year (e.g. high flu season leading to complications).

Policies for Facilities with Zero Readmissions during the Performance Period

LeadingAge has been witness to member facilities that have zero readmissions for a given performance period and yet have a 18% readmission rate applied to their facility. The goal of the readmission measure for the SNF VBP program is to incentivize SNFs to reduce their readmission rates. The CMS practice of shifting these zero readmission SNFs to the mean is unfair both from the perspective of an opportunity to earn a bonus, not to mention it erroneously assigns a readmission rate that ties to nothing in reality. In addition, we also recognize that for those facilities with 25 or fewer short stay admissions, the percentages of readmissions are easily skewed both positively and negatively. At a minimum, these facilities should receive the entire 2% of Medicare FFS rate back and their

actual readmission rate (0%) should be published on Nursing Home Compare. If the program is really committed to rewarding those SNFs that reduce or eliminate readmissions in their facilities, then these zero readmission facilities should be eligible for amounts in excess of the 2% to recognize and reward their success.

One way to approach the zero readmission issue might be to use a moving average, which are commonly used as a smoothing technique applied to data with low event rates. Each quarter CMS could average the last two years of data together with the most recent quarter as the final data point. The subsequent quarter, the last two years ending with that quarter, i.e., dropping the previous oldest data point, would be averaged, and so on.

As a result, for those SNFs with a small number of beneficiaries (e.g., fewer than 25 in the denominator), LeadingAge recommends that CMS consider using a two-year moving average for calculating the SNFRM or instead compare readmission rates for all SNFs with 25 or fewer admissions (denominator) to each other separate from the broader group and then rank and apply VBIP within in this subgroup based upon the same achievement and improvement threshold percentiles as the main group.
Alternatively, LeadingAge would recommend CMS consider testing an adjustment to the formula that factors in the size of the facility or establishes a flat VBIP percentage for these SNFs and then stratifies the rates and VBIP for the remaining SNFs that have some readmissions.

Logistic Exchange Function

CMS proposes to adopt a logistic function for the FY2019 SNF VBP Program and beyond. Based upon the results of CMS' analysis of various exchange functions, LeadingAge supports CMS' use of the logistics function based upon its findings that it encourages

SNFs to continually strive for improvement on their readmission rates and results in a net positive payment for the greatest number of SNFs.

Extraordinary Circumstances Exception Policy

It goes without saying that exceptions should be made for SNFs affected by natural disasters or other circumstances beyond the facility's control. We appreciate CMS recognizing these extraordinary circumstances and ensuring that SNFs are not negatively affected should these situations arise. LeadingAge, therefore, supports the inclusion of such a policy under the SNF VBP program.

Correction Reports and Phase Two Review and Comment Process

LeadingAge supports the fact that CMS has established a process by which SNFs can seek corrections to the quality measure data for this program. However, given that SNFs do not receive patient/resident-level data and the fact that the data can be up to two years in the past, it is unclear what evidence would be sufficient for a SNF to submit to challenge an erroneous performance score or ranking.

Additional information used to calculate a SNF's VBIP and readmission rate score would be helpful for transparency purposes including: their predicted readmission rate, their expected readmission rate, the national average, the SNF's baseline and performance period rates, the SNF's rank related to their calculated score, and achievement and improvement thresholds.

LeadingAge recommends that CMS make available patient level and other claims data outlined above that substantiates the SNFRM calculation. This is the only way possible that a SNF would be able to successfully challenge an error or understand its score.

Publishing SNF VBP Program performance on Nursing Home Compare

CMS is proposing to begin publishing SNF VBP performance information on Nursing Home Compare no later than October 1, 2017. LeadingAge seeks further clarity on whether this proposal will result in replacing the current readmission rate information and definition used on Nursing Home Compare for this measure or whether the SNF's VBP rank will merely be added.

LeadingAge and its SNF members find it frustrating that CMS is currently using multiple definitions or formulas for calculating readmission rates for different programs--SNF VBP, SNF Quality Reporting Program and Nursing Home Compare. If this proposal is moving toward the use of a single readmission measure for SNFs, we would applaud those efforts. Thus, in general, LeadingAge supports CMS moving toward the use of a single readmission rate definition applied to SNFs for VBP, the Quality Reporting Program and Nursing Home Compare. Specifically, we support the publication of SNF VBP rank instead of publishing the complicated SNFRM rate as we believe the ranking information will be more consumer friendly.

Quarterly SNF Confidential Feedback Reports

Current confidential feedback reports provide minimal data to SNFs with little insight into the why or who related to the readmission number. Additional, timely and more frequent patient-level information is important, especially when these readmissions occur after the

beneficiary has returned home, as the SNF would not be aware of the circumstances leading to the readmission or that a readmission had occurred. Both pieces of information would be helpful as SNFs strive for reductions in readmissions for this population. At a minimum, CMS should provide SNFs with the names of beneficiaries readmitted so they are able to validate the CMS rate calculations but also are able to conduct a root cause analysis to improve their processes to avoid future potentially preventable readmissions. However, CMS has a great opportunity to provide a full-view picture of the clinical pathways and outcomes of beneficiaries to providers and have a real effect on the quality delivered as CMS has all the fee-for-service claims data. While SNFs have access to real-time MDS data, this only provides an inside the organization view.

LeadingAge recommends that CMS provide a more robust Quarterly Confidential Feedback Report that helps SNFs identify quality practices, and gives them the tools to conduct thorough root cause analysis. The following are suggested items for inclusion in these reports:

- Names of beneficiaries triggering a readmission - This information is necessary to assist providers in reviewing their data and the correction reports provided. It will also facilitate quality improvement within the SNFs as they will be able to conduct root cause analysis of the specific cases that were readmitted. This patient-level data is the only way possible that a SNF would be able to successfully identify and challenge an error.

- Predicted and expected rates used to calculate the standardized risk ratio for the prior rolling 12 month window - LeadingAge recommends this data be calculated quarterly with a rolling 12 month timeframe. This provides the SNFs with a view to

their ongoing performance and reinforces continued focus on readmissions as the changes can be seen as they improve.

- National benchmark rates used to calculate the achievement and improvement scores - This information is necessary to allow SNFs to estimate how their readmission rate compares to their peers.

- Peer ranking information - This comparison should minimally include national rates listing readmission rates at the Top 10%, 50% and bottom 40% threshold. Ideally, these reports should also include state, regional or a MSA-level benchmarks as well given that the goal is to improve care and reduce readmissions, and given that CMS has all the fee-for-service claims data at its disposal,

- SNF-specific trend data and top causes of readmission - If the goal is to improve performance, then CMS should leverage the claims data at its disposal to help facilities, especially those with more limited resources. By analyzing the available data, CMS could provide reports to providers that display: their overall readmission rate, their rate by diagnosis category (e.g., diabetes, respiratory, cardiac, dementia, etc.) and compare that to the average length of stay for those diagnoses, identify the main causes for readmissions, number of days after discharge from the SNF that the readmission occurred and possibly, optimal care delivery information (e.g., beneficiaries with an ALOS of X for condition Y had lower readmission rates than those with a shorter ALOS). This data could be provided and updated more quickly than any other source available to providers and, again, give SNFs a view into what happens to the patient after they leave the SNF. Individual SNF trending information (e.g., facility's performance by quarter

and for past three years) could also be beneficial. Each one of these data elements could help facilities focus their attention based on these potential predictors and/or initiate conversations with providers in other parts of the care continuum to improve the care delivery and transition processes. Providing this information could also lead to real care transformation and more cost effectively than each facility paying a data vendor money to conduct this analysis with old data.

Transition from SNFRM to SNFPPR

LeadingAge articulated its concerns in detail in its response to the previous year's proposed rules but culminated in noting that NQF MAP's position on this measure is "encourage further development." Upon review of the Technical Report on the PPR measure, the risk-adjusted SNF Distribution looks very concentrated, which raises the question of how easily this measure will lend itself to appropriately assign VBIPs given the clustering of SNFs. We continue to support additional testing and analysis of this measure given the potential impact of this measure on beneficiaries both from an access and quality perspective.

In view of the foregoing, LeadingAge continues to recommend that replacement of the SNFRM by the SNFPPR be deferred pending full endorsement by the NQF. Additionally, if CMS aims to begin using this measure in FY2021, we also would suggest that it begin including the rate calculated by this measure on the confidential feedback reports so providers can see and understand how it differs from the current measure.

Risk-adjustment based upon Socio-Economic Risk Factors.

LeadingAge believes that social risk factors impact health care outcomes and as such should be applied as an adjustor to quality measures. In 2015 and 2016, the National Academies Committee on Accounting for Socioeconomic Status in Medicare Value-based Payment Programs thoroughly examined socio-economic and social determinants of health risk factors and found that in many cases they impacted health outcomes. As such, quality measures should be adjusted to account for these socio-economic factors and social determiners of health should especially as they relate to value-based payment programs.

LeadingAge believes that Social Risk Factors are important considerations for positive outcomes. The World Health Organization http://www.who.int/social_determinants/en/ defines social determinants of health as the conditions in which people are born, grow, live, work and age. An Ad hoc committee of the National Academy of Sciences, Engineering and Medicine http://nationalacademies.org/hmd/Activities/Quality/Accounting-SES-in-Medicare-Payament-Programs.aspx identified a list of measurable social risk factors for potential use by Medicare. This committee called for attention to these factors, in both quality measurement and value-based payment systems under Medicare. In particular, dual status was the most strongly associated with poor health outcomes.

LeadingAge recommends, at a minimum, that dual eligibility or dual status for Medicare and Medicaid be used as an individual-level risk adjustment to the reported measures. We also recommend the following be considered as individual-based risk factors:

- Education level

- Limited English Proficiency
- Living alone

Other Issues - Possible Burden Reduction in the Long Term Care Requirements

Grievance Process

LeadingAge agrees with the importance of an established and effective grievance process to ensure the prompt resolution of grievances. Nursing home residents must be made aware of their rights, be able to voice grievances and subsequently, be able to file a grievance. We also agree the process and responsibility for managing and responding to grievances must be timely, clear and consistent and well served through a designated facility policy and procedure. Nevertheless, the final rule, entitled Medicare and Medicaid Programs: Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68688 (Oct. 4, 2106) (the "Final RoPs Rule"), adds both unnecessary labor and financial burdens to an organization. The mandate of a designated "Grievance Official" does not afford facilities the flexibility to handle grievances as their particular needs dictate. While technically an existing staff member could fulfill the duties of the grievance official, as a practical matter the duties outlined in the Final RoPs Rule make it nearly impossible for facilities to utilize existing staff. Hiring an additional staff member to serve as the grievance official would add a labor expense including potential benefits. Further, facilities could be duplicating roles and responsibilities that are similar to a Compliance Officer. Facilities currently have established grievance processes in place, and during annual surveys and/or complaint investigations by State Agencies, grievances and the grievance process are reviewed and surveyed, thereby rendering the requirements of the Final RoPs Rule unnecessary and overly burdensome.

The Final RoPs Rule requires that evidence related to grievances must be maintained for at least 3 years. LeadingAge has concerns on the feasibility, both financially and structurally, for facilities to meet this requirement. Facilities vary on the level of electronic storage and physical storage to maintain such records for a period of at least 3 years. In addition, the cost for either type of storage adds to annual expense and erodes funding that could be allowed to improve quality of life in a facility.

Again, LeadingAge members have raised concern that extensive additional documentation and duties with respect to grievances will require both additional staff interventions and direct financial investments that will take valuable resources away from pressing needs elsewhere in the facility and have the potential to take time away from resident care. Accordingly, LeadingAge respectfully requests that much needed flexibility be returned to facilities to ensure residents' rights to be heard and effect change through the grievance process in a manner that works for the individual facilities.

Quality Assurance and Performance Improvement (QAPI)

LeadingAge has been a strong supporter and promoter of QAPI since its adoption under the Affordable Care Act (ACA). However, we are very concerned with the CMS approach to implementation of the statutory mandate. The provisions in the proposed rule far exceed the statutory language and significantly modify the current QAA-related Requirements for Participation for Long-Term Care Facilities.

The Final RoPs Rule contains provisions that require a facility to provide the State Survey Agency (SSA) with access to quality data, analysis and reports. This information should remain protected and privileged, so facilities can fully embrace transparency without blame to hardwire a culture of high performance and quality. LeadingAge members are concerned

about the possible implications of making this information public by giving access to the SSA and thereby jeopardizing previously non-discoverable status. We are raising the concern about ensuring that providers are able to identify organizational priorities for improvement. This should not be an exhaustive list to achieve perfection, but a focused approach to improving systems based on what the facility has identified as important. Stated simply, each facility and its residents are unique and require flexibility in order to have a higher functioning quality assurance, quality improvement program.

Long-term care facilities should have the flexibility to develop, implement, and maintain an effective QAPI program. The requirements in the Final RoPs Rule are rigid, inflexible, overly detailed and encompass the full range of care and services in a facility. The QAPI program in a facility should be designed to prioritize continuous quality improvement activities centered on resident outcomes and both quality of care and life. Facilities should be able to monitor their QAPI program and make necessary changes depending on outcomes and data. Accordingly, LeadingAge recommends revisions to the QAPI section of the Final RoPs rule to afford facilities flexibility in the requirements that allow them to focus on the most pressing challenges.

Discharge Notices

LeadingAge agrees with CMS' re-evaluation of its requirement for long-term care facilities to send discharge notices to the state Long Term Care Ombudsman. We concur that by re-evaluating and stepping back from that requirement, the initial objective to reduce inappropriate involuntary discharges can still be met. LeadingAge members support notification to the state Long Term Care Ombudsman only in cases of involuntary transfers or discharges.

The Final RoPs Rule requirement that mandates reporting of every non-resident initiated transfer or discharge of to the state LTC Ombudsman creates an unnecessary burden on both providers and the state LTC Ombudsman, both in terms of needless paperwork and an overload of information that merely serves to distract the LTC Ombudsman from focusing on true cases of involuntary transfers or discharges. The notice could cause delay in transfer/discharge and add confusion to an emergency situation or life threatening need for transfer/discharge. We have been informed by state LTC Ombudsman throughout the country that their offices do not want all notices and cannot handle the amount of paperwork that would be funneled to them. LeadingAge recommends the requirement for transfer/discharge notices be rewritten to focus on providing notice to the State Long-Term Care Ombudsman only in situations involving true involuntary transfers/discharges.

Abuse Reporting

LeadingAge agrees that all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property, are reported. However, we strongly oppose the reporting of any alleged violations immediately, but not later than two (2) hours. The 2-hour time-frame is unduly restrictive and burdensome for several reasons, as illustrated below.

> One of our members outlined the priorities and steps they take in the event of an alleged violation of abuse:
>
> 1. Protect the resident from the suspected abuse - A resident may need be to be transferred out of bed and relocated down the hallway into another portion of the facility. The resident may be scared or frightened, so staff would have to weigh whether to move the resident abruptly so they can meet the reporting deadline or stay with them where they are to avoid startling or scaring them. The member

stated that they always try to take the time necessary to calm and protect the resident.

2. Protect the resident and potentially other residents and staff - Staff might have to determine the identity of the alleged offender and locate a picture (if possible) to notify all other staff members about what to do if the alleged offender arrives on site.

3. Assess if anyone else is at immediate risk.

4. If others are at risk, the facility staff will need to implement contingency plans to protect others

5. Provide instructions to staff

6. Notify administration of the event

7. Notify the resident representative(s) and anyone else the resident would like the facility to notify. This may involve a series of voicemails and returned calls

8. Notify the Medical Director by voicemail and possibly have to wait for a return call

9. Notify the police

10. Once police arrive at facility, he/she will need to be escorted to the resident and/or the resident's room. The police will begin their investigation and will include interviews.

11. The police investigation could add steps to their reporting. There may be photos that need to be taken. This may involve the facility transporting and transferring the resident again within the facility. Again, the member states that they do not want to move the resident abruptly.

12. Potential transfer to the hospital - The resident may need to be transferred to the hospital, thereby requiring that paperwork will need to be prepared and transportation arranged.

13. Communication with the ER – The facility nurse will need to call ahead to the ER inform them of the situation

14. The Administrator then begins the notification to State Survey Agency – **At this point, it's likely that the 2-hour reporting window has long since closed**.

15. The abuse notification report is then created and faxed to the SSA.

This is just one example of the how the 2-hour reporting rule is not only burdensome but actually detracts from the care provided immediately after a suspected or alleged abuse. LeadingAge believes, without question, the priority should be the care and well-being of the resident. The resident may need direct care and reassurance, as well as immediate interventions to ensure all residents are protected from harm or danger. Pulling staff in at all hours of the night to sit in an office and complete a report to file within 2 hours is simply not an appropriate use of resources in an emergency situation in which resident care should always take precedence.

Accordingly, LeadingAge requests that the 2-hour notification be revised to permit notification within 24-hours so that facilities can devote the necessary time, attention and resources to the residents they serve.

Electronic Health Records (EHR)

Many LeadingAge members commented that compliance with certain provisions of the Final RoPs Rule—especially QAPI and the Facility Assessment--will necessarily require

providers to have EHR. Existing certification programs for EHR are geared toward Meaningful Use incentives for eligible hospitals and eligible providers. We, therefore, encourage the Department of Health and Human Services (HHS) to accelerate the development of a modular certification program for long-term and post-acute care providers. We also would like to point out that increased use of EHRs by eligible providers, as well as non-eligible providers who have the resources and invested in this technology, puts smaller, non-affiliated and particularly rural providers at a significant disadvantage and threatens their ability to remain in operation. Our rural members in particular fear that the technology gap merely serves to move the field toward a corporate model and away from a model that emphasizes the care and personal interactions that residents deserve.

Accordingly, we urge CMS and the HHS Office of National Coordinator (ONC) to consider ways to encourage the adoption and use of these tools by such providers to prevent this digital gap from further increasing and leaving smaller providers unable to comply with the Final RoPs Rule. We also urge CMS to provide for delayed implementation of those provisions of the Final RoPs Rule that necessitate the use of EHR in order to have timely data for compliance.

Facility Assessment (FA)

The requirement for an annual FA requires a comprehensive assessment of all relevant factors involved in facility operation and services. As such, it presents the most burden to our members, particularly because it is duplicative of information required for other provisions of the Final RoPs Rule, including, *inter alia,* QAPI, compliance/ethics, emergency preparedness, and infrastructure maintenance plans, yet the information must be re-packaged in a stand-alone FA that becomes obsolete as soon as it is completed. Because of the ever changing nature of a facility's operations and census, a facility would have to

constantly update its FA to present an accurate picture or otherwise risk citation. This will require an outlay of effort and resources that far exceed its worth and will necessarily take critical staff away from resident care and the day-to-day tasks that keep a facility operating safely and efficiently.

The outcomes of a nursing home's organizational decision-making are evident in the quality of care and services provided and are already addressed within the regulatory structure by the array of existing quality of care and quality of life requirements. While the concept of a documented facility assessment process as a strategic planning approach to facilitating operations may appear ideal in concept, the variables identified in the FA provisions are, as stated above, subject to change on a daily basis in the vast majority of nursing homes. To establish a requirement of participation that measures compliance against an annual regulatory review of such a plan, even with provisions for periodic review and updates by the provider, is counter-intuitive to assessment of the nursing home's ability to manage and respond to the care and service need of their residents on a day-to-day basis. Nursing homes must retain the flexibility necessary to respond to the variability of their ongoing functioning needs. Organizational decisions and operational approaches should not be specifically directed or managed by CMS and/or be subject to compliance determinations based on a single document review conducted on an annual basis. Accordingly, we ask that CMS reconsider the requirement for the FA. It creates an enormous burden on providers (particularly small, rural facilities) and will not serve to enhance facility performance or regulatory oversight, nor will it benefit the care and services provided to residents.

Infection Prevention and Control

LeadingAge and our members recognize the role that infection control plays in promoting quality. That said, the Infection Prevention and Control Plan (IPCP) provisions of the Final

RoPs Rule are so strict in terms of required elements and specifications that it will be virtually impossible for a facility to tailor the IPCP to its particular needs, despite the fact that it is to be based on the Facility Assessment. Moreover, because primary responsibility for the development, implementation, oversight, operation, review and revision of the IPCP is to rest with a qualified Infection Prevention and Control Officer (IPCO), facilities will be forced to hire an additional staff member with the appropriate educational background and certification to serve as the IPCO, all without any increase in funding from government health care programs. LeadingAge heard from many members, particularly those in rural areas. These members said it will be both practically and financially impossible for them to find such professionals in their labor market.

LeadingAge, therefore, asks that CMS revise the Final RoPs Rule to allow greater flexibility in the development of the IPCP that would allow facilities to design a program that meets the needs of each individual facility based on existing policies and procedures, compliance history and other factors. Also, LeadingAge strongly emphasizes the need for CMS to build greater flexibility into the IPCO position, including the ability to share job dies, to all the IPCO to serve multiple nursing homes and permit tele-visits for facilities in rural areas as well as those areas experiencing workforce shortages.

Training

Many members are concerned that the training requirements themselves will require them to have to hire additional staff, simply because of the number of topics that must be covered, the scope of the training on those topics and the time such training will take away from staff interaction with, and care of, residents. While the Final RoPs Rule purports to afford providers with flexibility in how they train, this flexibility is illusory given the expansion of who must be trained, on what topics they must be trained and how often they must be

trained. As such, the training requirements are unduly prescriptive and burdensome. A better approach would be to target enhanced training requirements based on a facility's compliance history in the areas specified by the Final RoPs Rule.

Cumulative Effect

The genesis of our members' frustrations with the Final RoPs Rule provisions discussed above emanates directly from the burdensome regulatory environment in which they are forced to operate without corresponding increases in available resources. The vast majority of LeadingAge members provide excellent care and services to their residents, and they put residents' needs first. They become increasingly frustrated when paperwork takes precedence over resident interaction and care. One LeadingAge member who reached out to us on this issue said everyone—regulators, provider, residents and families—all want the same thing: an environment that recognizes and supports the dignity and quality of life of nursing home residents. Yet that member decried the piling on of regulation upon regulation upon regulation that leaves little time to fulfill their mission to provide excellent, person-centered care and to interact with their residents in a truly meaningful way. The member urged CMS to "hit the pause button," take a step back, and look for ways to let good providers continue to do good things in the lives of the seniors they serve. Specifically, LeadingAge renews its call for CMS to delay the implementation of Phases II and III as well as afford providers a sufficient period of time *after* guidance is issued by CMS on the Phase II and Phase III requirements to work toward implementation. This will allow providers to incorporate CMS' expectations into their plans for compliance rather than to guess about CMS' expectations and have to go back and revise their policies, procedures and operations.

Other – CMMI Solicitation

CMS asked for input on additional ways it might consider transforming the health care delivery system and Medicare program. Specifically, CMS asked what improvements can be made to the health care delivery system to reduce unnecessary burdens for providers and consumers. CMS also is seeking ideas for payment system redesign, changes to conditions of participation, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those from Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery and facilitation of individual preferences.

LeadingAge maintains that there are a number of opportunities to move our health care system along to providing better care and services to older adults through an integrated services and supports model that spans Medicare, Medicaid and private pay dollars. To date, despite the CMS' efforts to encourage and test models to break down fragmentation in our system, many "clinically integrated" health systems are only integrating one small piece of the puzzle--physician and hospital care. While this is a good start, it is still missing critical pieces of the individual's health and wellness picture. It fails to incorporate the services they receive in their home to support their health and basic daily living needs (e.g., food, transportation, medication assistance, etc.). Finally, if an older adult's services and supports are only integrated once they arrive at the hospital, then the system is missing an opportunity to prevent the high-cost hospitalization in the first place. Older adults have a single set of comprehensive needs, which must be addressed comprehensively, taking into account environmental factors and available resources. We must not only identify and treat "what" the symptoms are (diagnoses) but we must also understand the "why" these

symptoms are present (e.g., nutrition, stable housing, lack of transportation, etc.) to ensure the treatment achieves more high-value results. Simply medically treating symptoms will not get us the cost and quality answers we seek.

LeadingAge believes in the need to re-envision our current delivery system and existing models of integration to center on the older adult's needs--their housing, their medical needs, their supports, their finances--instead of starting the conversation from a medical and/or symptom perspective. By changing our starting point, we can optimize our use of available resources--financial and workforce--and achieve better outcomes for older adults by creating community-level ecosystems of health and aging-related services that address and support older adults as they age, thereby enabling them to live their best lives.

To this end, we urge CMS to incorporate measures, develop payment models and test new care delivery models that seek to achieve true clinical, social and financial integration of care, supports and services for older adults. Specifically, we believe some of the following initiatives could move our health care system in this direction:

- Expand the existing Medicare wellness visit benefit to include a comprehensive assessment that also evaluates an older adult's needs for services and supports to remain independent and manage their health and wellness. This concept has been long supported by the American Geriatrics Society. If we are to successfully manage and integrate the right services and supports for an older adult, it is essential to understand the starting point for these individuals, which includes understanding things like what current informal support structure do they have, what tasks are becoming more challenging, such as buying groceries, housekeeping, etc.

- If we expect to achieve true integration, collaboration and coordination of all supports and services not just the medical services, then we need to ensure that performance measures for physicians (primary care and hospitalists) in MIPS/QPP encourage and assess their coordination with LTSS and PAC providers.

- Medicare should reimburse LTSS or community-based organizations responsible for coordinating care for Medicare or Dual Eligible beneficiaries and develop a corresponding code similar to the Medicare Chronic Care Management CPT code available to physicians. Physicians are not the only providers who coordinate care for older adults. In fact, many older adults who receive LTSS actually have greater interaction--often daily--with their care providers in their nursing home, assisted living facility or their home in the community. As such, these individuals are better positioned than physicians in a 15-minute clinic visit to coordinate care, work with other providers to modify care plans, and understand the full scope of providers engaged in a beneficiary's care.

- Waive the 3-day inpatient hospital stay requirement for all integrated service models where a comprehensive care or service plan is in place and a care coordinator is involved. Eliminate the observation status under Medicare fee-for-service for the purposes of determining nursing home eligibility for post-acute care. If post-acute care is required following any hospital stay and is prescribed by the discharging physician, then it should be covered by Medicare.

- Change current Medicare and Medicaid reimbursement policies to permit Medicare and Medicaid reimbursement for those services that optimize the health or functioning of the older adult in cases where: the older adult is part of an integrated service model; a comprehensive risk assessment has been conducted; and a

corresponding care and service plan that outlines the older adult's needs has been developed.

We know that an integrated service model can achieve cost-effective, improved outcomes for older adults. Many LeadingAge members throughout the United States have firsthand knowledge and some demonstrated success under the Model 3 Bundled Payment for Care Improvement initiative where they serve as episode initiators and conveners of episodes of care and bear the financial risk. Others are partnering with Medicare Accountable Care Organizations (ACOs) to co-create and utilize cross-setting clinical pathways and best protocols that follow Medicare beneficiaries from the hospital to the transitional care unit to their home.[1] Unfortunately, regulatory and financing barriers prevent or limit the ability of LeadingAge members from fully realizing and scaling these new integrated service models. In this regard, we suggest additional avenues for PAC and LTSS providers to participate in Medicare and Dual Eligible payment and care delivery models:

- Amend existing Medicare ACO and other CMMI demonstration language to:

    - Expand the definition of what types of providers can lead these models to include LTSS, PAC and other community-based organizations and providers.

    - Make these same providers eligible to apply for the Advanced Investment Model (AIM) ACO. This would allow them to access an "advance" on their projected shared savings to allow for the necessary upfront infrastructure

[1] Christian Horizons self-reported achieved savings of 49.2% for 16 episodes with 0 readmissions and average SNF length of stay of 18.7 days. PACN of Cincinnati results at: http://postacutecarenetwork.com/resources/bundled-payments/; Advisory Board: https://www.advisory.com/daily-briefing/2016/09/20/voluntary-bundled-payment-first-year-data

investments. Like rural providers, often these aging service organizations have limited access to available capital for such an upfront investment and would not otherwise be able to participate.

- Broaden the definition of "provider" under Medicare Advantage laws/rules to include senior living and assisted living providers thereby allowing them to develop and deliver provider-sponsored Medicare Advantage plans.
- Consider revising Medicare Advantage plan requirements for provider-sponsored plans similar to those used for PACE programs (e.g., reserve requirements).

Finally, we would like to see CMS test via the Center for Medicare and Medicaid Innovation additional models that begin in the community instead of being triggered by a hospitalization and would allow post-acute care providers and/or LTSS providers to be the integrator or coordinator for an older adult's services and supports. We are interested in discussing many different forms such as a chronic care bundled payment type of arrangement and all the way up to a fully-integrated, cross-continuum service model that requires a community-based hub of providers to conduct a comprehensive risk assessment, develop an aging service plan, coordinate services through a single service coordinator, and consolidate and integrate funding for older adults in their hub. Provider payment options might look like those available under the Next Generation ACO model (e.g., FFS, PMPM, Capitation).

Again, LeadingAge appreciates the opportunity to submit comments on this proposed rule. Please do not hesitate to contact us if you wish to discuss any of these comments further.

Sincerely,

Cheryl Phillips, M.D.
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