June 26, 2017

The Honorable Seems Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1679-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

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 FY 2020 (42 CFR Parts 409, 411, 413, 424, and 488) (May 4, 2017)

Dear Administrator Verma:

On behalf of the Association of Rehabilitation Nurses (ARN) – representing more than 5,000 rehabilitation nurses and more than 13,000 Certified Registered Rehabilitation Nurses (CRRN) that work to enhance the quality of life for those affected by physical disability and/or chronic illness – we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule implementing the Fiscal Year (FY) 2018 Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF), SNF Value-Based Purchasing Program (VBP), SNF Quality Reporting Program (QRP), Survey Team Composition, and Proposal to Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for FY 2020.

Overview of Rehabilitation Nursing

Rehabilitation nursing is a philosophy of care, not a work setting or a phase of treatment. Rehabilitation nurses base our practice on rehabilitative and restorative principles by: (1) managing complex medical issues; (2) collaborating with other specialists; (3) providing ongoing patient/caregiver education; (4) setting goals for maximum independence; and (5) establishing plans of care to maintain optimal wellness. Rehabilitation nurses practice in all settings, including freestanding rehabilitation facilities, hospitals, long-term subacute care facilities/SNFs, long-

term acute care facilities, comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and private practices.

Rehabilitation nurses take a holistic approach to meeting patients' nursing and medical, vocational, educational, environmental, and spiritual needs. We begin to work with individuals and their families soon after the onset of a disabling injury or chronic illness and continue to provide support and care, including patient and family education, which empowers these individuals when they return home, to work, or to school. Rehabilitation nurses also often teach patients and their caregivers how to access systems and resources.

ARN supports efforts to ensure that people with physical disability and chronic illness have access to comprehensive quality care in the care setting that is most appropriate for them. Specifically, as a part of its mission, ARN stands ready to work with policymakers at the local, state, and federal levels to advance policies and programs that promote maximum independence for people living with physical disability and/or chronic illness.

Proposed Changes to the SNF PPS for FY 2018

ARN members are committed to providing the highest quality, state-of-the-art care to Medicare beneficiaries across all care settings, especially in SNFs. As part of this dedication to patient care, we support the agency's efforts to improve quality and outcomes for Medicare beneficiaries and promote higher quality and more efficient health care for Medicare beneficiaries, specifically in SNFs. Linking a portion of Medicare payments to quality measures will assist in transforming Medicare from the current fee-for- service (FFS) model to a model based on quality and value. We stand ready to work with the agency on the following and other issues to ensure that the SNF QRP meets the needs of Medicare beneficiaries, holds providers appropriately accountable for quality and outcomes, and does not unduly burden providers in implementation and compliance.

Measuring and Accounting for Social Risk Factors in the SNF QRP

ARN maintains a steadfast commitment to supporting the agency's objective "to improve beneficiary outcomes including reducing health disparities, and we want to ensure that all beneficiaries, including those with social risk factors, receive high quality care." We support the agency's efforts to improve outcomes and reduce health disparities and to "ensure that the quality of care furnished by providers and suppliers is assessed as fairly as possible … while ensuring that beneficiaries have adequate access to excellent care." To that end, we very much appreciate that the agency has concerns about "holding providers to different standards for the outcomes of their patients with social risk factors because we do not want to mask potential disparities or minimize incentives to improve the outcomes for disadvantaged populations." We thank the agency for seeking public comment on "which social risk factors might be most appropriate for reporting stratified measure scores and/or potential risk adjustment of a particular measure."

We previously have submitted comments to the agency about the need to utilize socioeconomic and demographic factors in risk adjustment for the proposed resource use measures. We understand the agency is considering factors such as dual eligibility for Medicare and

Medicaid/low-income subsidy, race, and ethnicity. We agree with those factors and would like to take this opportunity to reiterate our previous comments to the agency about further expanding the list of socioeconomic and demographic factors that are utilized in risk adjustment, with a focus on those that affect both discharge to community and 30-day readmissions measures, including:

1. Age;
2. Presence of support system (spouse, partner, children, and/or parents who are able to learn and are willing to participate in learning care and providing care);
3. Finances (does the individual qualify for aid such as low-income subsidy or have private funds to assist with care or is there a family/caregiver with the ability to stay home with the individual; how will the individual obtain equipment not covered under Medicare);
4. Education and healthcare literacy (the ability to understand the medical diagnoses and the care that is needed);
5. Physical ability of the caregiver (e.g. age of caregiver, presence of impairments in caregiver, weight and medical condition of caregiver);
6. Living conditions and home access;
7. Community resources available for respite;
8. Race and ethnicity;
9. Geographic area of residence;
10. Dual eligibility for Medicare and Medicaid;
11. Cognition; and
12. Presence of pre-morbid assistance with self-care.

In addition to utilizing these factors to make appropriate adjustments in the SNF QRP, ARN believes that utilizing the above factors during the assessment of patients would enable providers, in collaboration with the patient/caregiver, to develop a more comprehensive treatment and intervention plan that addresses these concerns, improves outcomes, and helps to prevent avoidable readmissions.

As CMS continues to develop and refine existing and planned SNF QRP measures, ARN encourages CMS to consider the following features of care furnished in a SNF:

- Assessment of family members and caregivers' capacity to assume patient care post-discharge;
- Coordination and collaboration on patient, family, and medical goals of care when patients' goals are to return to their home- or community-based setting; and
- Ethical considerations regarding ongoing care and family support for continuing or terminating complex medical care and the addition of language related to initiating and/or introducing palliative care.

Proposed Collection of Standardized Resident Assessment Data Under the SNF QRP

ARN strongly supports the *Improving Medicare Post-Acute Care Transformation (IMPACT) Act*, and believes that valid, reliable, and relevant measures are fundamental to the effectiveness of the SNF QRP. As part of the IMPACT Act implementation, we understand the agency is proposing

to define "standardized patient assessment data" as "patient assessment questions and response options that are identical in all four PAC assessment instruments, and to which identical standards and definitions apply." ARN represents rehabilitation nurses that work in all four PAC settings – SNFs, Long Term Acute Care Hospitals (LTCH), home health agencies (HHAs), and inpatient rehabilitation facilities (IRFs) – and as such, we support standardizing the definition as well as the implementation of this data collection effort. Further, we support the agency's goal of collecting standardized patient assessment data "to drive improvement in health care quality across" the four PACS settings.

We share the agency's concerns that the "assessment questions and response options in the four PAC assessment instruments are not currently standardized with each other [and] as a result, questions and response options … cannot be readily compared." We support the agency's effort to standardize the questions and responses across all PAC settings to help "enable the data to be interoperable, allowing it to be shared electronically, or otherwise between PAC provider types."

We wish to note a concern with respect to the proposed change from multiple assessments to one assessment performed on admission and one on discharge. At present, the current MDS assessment schedule, along with change of therapy (COT), end of therapy (EOT), start of therapy (SOT), help to track resident progress, decline, or maintenance of function and provide essential clinical data to support patient-centered care. We have concerns that this change might have an adverse impact on patients.

Policy for Retaining SNF QRP Measures and Proposal to Apply That Policy to Standardized Patient Assessment Data

ARN understands and supports the current CMS policy that allows any quality measure adopted for use in the SNF QRP to "remain in effect until the measure is removed, suspended, or replaced" and agrees that this policy should be applied to the standardized patient assessment data that will be adopted by the agency for the SNF QRP.

Policy for Adopting Changes to SNF QRP Measures and Proposal to Apply That Policy to Standardized Patient Assessment Data

ARN understands that CMS adopted a subregulatory process to "incorporate updates to SNF quality measure specifications that do not substantively change the nature of the measure" and that substantive changes to measures are undertaken through formal rulemaking. ARN agrees with the agency that this approach be applied in the same manner to the standardized patient assessment data being adopted for the SNF QRP.

Quality Measures Currently Adopted for the SNF QRP

Potentially Preventable 30-Day Post-Discharge Readmission Measure

While ARN is generally supportive of the potentially preventable readmissions measure, we have several concerns, which we previously have expressed to the agency. ARN believes PAC facilities should not be penalized for conditions that prompt readmission which are unrelated to the

patient's initial reason for admission to the SNF. For example, hospitalization often changes the condition of a patient, increasing the likelihood of an unplanned readmission, which is outside the control of the PAC provider. Additionally, we believe CMS should account for differences in each SNF's mix of low-income patients when calculating readmission rates.

Further, as previously stated, ARN questions the rationale behind the exclusion for SNF stays where the patient had one or more intervening PAC admissions (in an IRF or LTCH) which occurred either between the prior proximal hospital discharge and SNF admission or after the SNF discharge, within the 30-day risk window as well as SNF admissions where the patient had multiple SNF admissions after the prior proximal hospitalization, within the 30-day risk window. The rationale states that "the focus is on the transition to the SNF from the hospital. Intervening stays make assessing this more complicated. For residents who have IRF or LTCH admissions prior to their first SNF admission, these residents are starting their SNF admission later in the 30-day risk window and receiving other additional types of services as compared to residents admitted directly to the SNF from the prior proximal hospitalization." ARN believes that this rationale could apply to any PAC setting and therefore disagrees with having this as an exclusion from the SNF denominator.

ARN also has serious concerns with the excluding SNF stays with a gap of greater than one day between discharge from the prior proximal hospitalization and admission to a SNF. The exclusion criteria fails to consider a medically complex patient that is treated in an IRF and subsequently readmitted within 30 days for an issue that may have been treated as a comorbidity. Given that a prior proximal hospitalization is defined as an inpatient admission to an acute care hospital, critical access hospital (CAH), or a psychiatric hospital, and IRFs are licensed as hospitals, we believe that admission to an IRF should be considered a proximal hospitalization and disagree that patients who are clinically different should be excluded.

Total Estimated Medicare Spending Per Beneficiary (MSPB)–Post-Acute Care (PAC) SNF QRP

ARN appreciates CMS's efforts to advance care management and improve the efficiency and coordination of care provided to patients in PAC settings by developing measures that allow for meaningful comparisons between providers in the same PAC setting. As we have previously commented to the agency, ARN urges CMS to clarify how the information collected by the MSPB-PAC SNF episode-based measure will be communicated to patients and providers, as we expect the efficiency of SNFs may be difficult to convey to beneficiaries in a meaningful manner. We have concerns the information made available to the public could unfairly be interpreted as a measurement of the PAC provider's quality of care, rather than an indicator of the facility's relative efficiency.

We understand and appreciate the intent of the MSPB-PAC SNF QRP measure is to ensure patients receive high quality care and address geographic variations in SNF spending. However, assessing SNF providers' efficiency based solely on the MSPB-PAC SNF QRP measure is inappropriate, given that some post-acute providers may treat a greater number of medically complex patients who require multi-faceted, highly skilled rehabilitation and treatment than other providers of the same type. ARN believes the MSPB-PAC measure may unintentionally

encourage SNFs to selectively admit or refuse patients based on the type and complexity of their conditions.

It is vitally important that individuals with chronic and disabling conditions are served in a setting that includes the provision of services that will optimize health outcomes and quality of life. The MSPB-PAC measure, which evaluates SNF providers' efficiency relative to the efficiency of the national median provider of the same type, fails to take into consideration the health needs and desired outcomes of each patient. We are concerned that SNFs will be assessed based solely on cost per patient, without accounting for the superior patient outcomes facilitated by SNFs.

While ARN supports CMS's efforts to align the MSPB-PAC measures with the hospital MSPB measure, stipulated by the *IMPACT Act*, as the development of the MSPB-PAC resource measures continues, we encourage CMS to take into consideration the possible financial incentives for hospitals to prematurely discharge patients to PAC facilities. A recent study, published in the journal *Medical Care*, suggests that some hospitals may prematurely discharge patients to post-acute settings as a substitute for prolonged inpatient care, thus inflating PAC facilities' costs, increasing hospital readmission rates, and distorting measurement.[1]

Discharge to Community

ARN has concerns with the proposed exclusion of post-acute stays that end in discharge to the same level of care, as we believe CMS's proposed exclusion criteria fails to consider when a patient's "home" is a custodial nursing facility and the patient's post-acute episode involves a discharge back to his or her "home." In such circumstances, including the final post-acute provider in the discharge to community measure when a patient is discharged to the originating level of care, but in essence, is returning home, may distort the findings of the quality measure. We encourage CMS to design a quality measure that is capable of capturing the difference between a patient's return to his or her home and a patient's post-acute episode that involves transfer to the same level of care.

ARN also believes that patients who have been discharged to the community and expire within the post-discharge window should not be excluded from the discharge to community quality measure, given the variation in characteristics of SNF patients. We encourage CMS to exclude patients from the Discharge to Community-PAC SNF QRP who pass away within the post-discharge window after being discharged to the community, as the types of patients treated in SNFs greatly varies and can lead to an inaccurate reflection of the quality of care.[2]

Drug Regimen Review Conducted with Follow-up for Identified Issues-PAC SNF QRP

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[1] Sacks, G. D., Lawson, E. H., Dawes, A. J., Weiss, R. E., Russell, M. M., Brook, R. H., Zingmond, D. S., Ko, C. Y. "Variation in Hospital Use of Postacute Care After Surgery and the Association With Care Quality." *Medical Care* 54.2 (2016): 172-179.

[2] Proposed Measure Specifications for Measures Proposed in the FY 2017 IRF QRP NPRM (April 2016). Retrieved from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/Downloads/Proposed-Measure-Specifications-for-FY17-IRF-QRP-NPRM.pdf

ARN supports the Medicare Payment Advisory Commission's (MedPAC) recent comments[3] on the drug regimen review measure. We concur with MedPAC that CMS should consider the development of a measure that evaluates how PAC providers are supporting medication reconciliation throughout the care continuum and whether a PAC provider is sending medication lists to either the next PAC provider, or if being discharged home, to the patient's primary care provider. It is imperative that all health care professionals responsible for the patient's care are aware of the patient's prescribed medications. Requiring providers to transmit medication lists to relevant providers may enhance adherence and improve monitoring of the patient's condition, which may help to prevent avoidable readmissions and unintended medical harm.

SNF QRP Quality Measures Proposed Beginning With the FY 2020 SNF QRP

ARN appreciates the agencies ongoing effort to improve the quality of care and ensure appropriate resource allocation among PAC settings, including SNFs. We understand the agency is proposing new measures for implementation beginning in FY 2020. Overall, ARN believes the expansion of core SNF measures to include National Quality Forum (NQF) IRF measures is appropriate. Measures should be clinically relevant or representative for a given setting or patient population and measures must be meaningful in order to be useful. Patient-reported outcomes and measures that are meaningful to patients and families also should be included. Most importantly, the underlying theme (and the intent of the *IMPACT Act*) is that measures must be harmonious across settings. As such, adding measures from the IRF environment to the SNF environment is aligned with this effort.

Proposed Modifications to Potentially Preventable 30-Days Post-Discharge Readmission Measures for SNF QRP

ARN supports efforts to ensure harmonious and equal measures across the post-acute care continuum and therefore agrees with the proposed removal of the readmission measure.

Proposed Standardized Resident Assessment Data Reporting for the FY 2019 SNF QRP

Change in the pressure ulcer to skin integrity
Functional Status

- Cognitive Function and Mental Status Data
- Brief Interview for Mental Status (BIMS)
- Confusion Assessment Method (CAM)
- Behavioral Signs and Symptoms
- Patient Health Questionnaire-2

Special Services, Treatments, and Interventions Data

- Cancer Treatment: Chemotherapy (IV, Oral, Other)
- Cancer Treatment: Radiation

[3] MedPAC March 25, 2016 Comment Letter. Retrieved from: http://medpac.gov/documents/comment-letters/medpac-comment-on-cms's-post-acute-care-quality-measures.pdf?sfvrsn=0

- Respiratory Treatment: Oxygen Therapy (Continuous, Intermittent)
- Respiratory Treatment: Suctioning (Scheduled, As Needed)
- Respiratory Treatment: Tracheostomy Care
- Respiratory Treatment: Non-Invasive Mechanical Ventilator (BiPAP, CPAP)
- Respiratory Treatment: Invasive Mechanical Ventilator
- Other Treatment: Intravenous (IV), Medications (Antibiotics, Anticoagulation, Other)
- Other Treatment: Transfusions
- Other Treatment: Dialysis (Hemodialysis, Peritoneal Dialysis)
- Other Treatment: Intravenous (IV), Access (Peripheral IV, Midline, Central line, Other)
- Nutritional Approach: Parenteral/IV Feeding
- Nutritional Approach: Feeding Tube
- Nutritional Approach: Mechanically Altered Diet
- Nutritional Approach: Therapeutic Diet

Medical Conditions and Comorbidity Data
Impairment Data

- Hearing
- Vision

SNF VBP

The Protecting Access to Medicare Act of 2014 (PAMA) authorized the SNF VBP, which beginning in FY 2019 will reward SNFs with incentive payments for the quality of care they give to people with Medicare with the goal of promoting better clinical outcomes for SNF patients and making their care experience better during skilled nursing facility stays.[4] ARN supports these efforts and welcomes a transition to a system that pays SNFs for "their services based on the quality of care, not just quantity of the services they provide in a given performance period."[5]

Accounting for Social Risk Factors in the SNF VBP Program

As noted earlier, ARN supports the agency's efforts to improve outcomes and reduce health disparities and welcomes the inclusion of socioeconomic status factors or socio-demographic status in the SNF VBP. In our experience, social risk factors can be barriers to patients being able to maintain the progress they have made in SNFs. Social risk factors directly impact where the resident may receive their PAC, how long they will be able to remain in the facility, and their risk of rehospitalizations. We encourage efforts to consider these factors and also support and encourage SNFs to assess and understand these issues and monitor their discharged patients and support them when they return to the community. We support the accounting for social risk factors in the SNF VBP Program.

[4] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html
[5] Ibid.

As noted earlier, ARN supports expanding the list of socioeconomic and demographic factors that are utilized in risk adjustment, with a focus on those that affect discharge to community, 30-day readmissions, and other outcomes and quality measures. Factors we recommend be considered include:

1. Age;
2. Presence of support system (spouse, partner, children, and/or parents who are able to learn and are willing to participate in learning care and providing care);
3. Finances (does the individual qualify for aid such as low-income subsidy or have private funds to assist with care or is there a family/caregiver with the ability to stay home with the individual; how will the individual obtain equipment not covered under Medicare);
4. Education and health care literacy (the ability to understand the medical diagnoses and the care that is needed);
5. Physical ability of the caregiver (e.g. age of caregiver, presence of impairments in caregiver, weight and medical condition of caregiver);
6. Living conditions and home access;
7. Community resources available for respite;
8. Race and ethnicity;
9. Geographic area of residence;
10. Dual eligibility for Medicare and Medicaid;
11. Cognition; and
12. Presence of pre-morbid assistance with self-care.

In addition to utilizing these factors to make appropriate adjustments in the SNF VBP, ARN believes that utilizing the above factors during the assessment of patients would enable providers, in collaboration with the patient/caregiver, to develop a more comprehensive treatment and intervention plan that addresses these concerns, improves outcomes, and helps to prevent avoidable readmissions.

Proposed FY 2020 Performance Standards

ARN agrees with the agency that the VBP Program will be "most effective at encouraging SNFs to improve the quality of care that they provide to Medicare beneficiaries if SNFs have the opportunity to earn incentives, rather than simply avoid penalties, through high performance on the applicable quality measures."

SNF VBP Reporting

Survey Team Composition

ARN appreciates the agency's interest in clarifying requirements for team composition and ensuring consistency. ARN believes the inclusion of registered nurses (RN) as part of the multidisciplinary team of professionals involved in certain surveys of SNF's and NF's. ARN urges the agency to ensure that the teams involved in surveys and investigations of complaints include RNs.

CMMI Solicitation

ARN is supportive of initiatives that are designed to promote higher quality and more efficient health care for Medicare beneficiaries. ARN encourages CMS to examine strategies around requiring facilities to clearly stipulate any service limitations to a resident or potential resident prior to admission to ensure patients and their families have the opportunity to make an informed decision regarding admission. Requiring facilities to inform patients about their resources, competencies, and qualifications will ensure patients are admitted to the appropriate site of care and could result in decreased hospital readmissions.

We also recommend that CMS develop an initiative that addresses nurse staffing. As the number of individuals accessing SNF care increases and the health concerns of individuals residing in LTC facilities become more clinically complex, it is essential that LTC facilities have a registered nurse on staff at all times to provide assessment, surveillance, and direct care to residents. Patients accessing care in these settings includes a mix of elderly individuals, younger residents with intellectual or developmental disabilities who are chronically ill, and residents in need of post-acute care and post-acute rehabilitation services.

Conclusion

ARN very much appreciates the opportunity to provide comments to CMS regarding the proposed rule implementing the FY 2018 SNF PPS, VBP, and QRP. We are available to work with you, your colleagues, the rehabilitation community, and other stakeholders to develop and implement payment policy changes that ensure access to quality care for Medicare beneficiaries with physical disabilities and/or chronic disease. If you have any questions, please contact me or have your staff contact our Health Policy Associate, Jeremy Scott (jeremy.scott@dbr.com or 202-230-5197). We thank you for your consideration of our concerns, recommendations, and requests.

Sincerely,

Stephanie Vaughn, PhD RN CRRN FAHA
President