AARP
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June 20, 2016

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1645-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule for FY 2017, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, and SNF Payment Models Research; CMS-1645-P

Dear Acting Administrator Slavitt:

AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

AARP appreciates the opportunity to comment on the Medicare skilled nursing facilities proposed rule for FY 2017. Our comments focus on the proposed quality measures, our recommendations to include additional measures to better assess person-and family-centered care and support family caregivers, and the Skilled Nursing Facility Value-Based Purchasing (SNF VBP) program.

Readmissions Measure in the Skilled Nursing Facility (SNF) Value-Based Purchasing Program and SNF Quality Reporting Program

For FY 2018, CMS proposes to adopt three new measures for the SNF Quality Reporting Program (QRP). As one of these measures, CMS proposes to assess the facility level risk-standardized rate of unplanned, potentially preventable hospital readmissions for Medicare fee-for-service (FFS) beneficiaries in the 30 days post-SNF

discharge from a prior admission to an inpatient prospective payment system (IPPS) hospital, critical access hospital, or psychiatric hospital. CMS proposes to employ this readmission measure as part of the SNF VBP program, as well as the SNF QRP. In its FY 2016 final rule, CMS also adopted a SNF 30-Day All-Cause Readmission Measure for use in the SNF VBP program. We recognize that CMS is required by law to adopt these readmission measures.

AARP is pleased that CMS proposes to hold SNFs accountable for the quality of care delivered to beneficiaries throughout their SNF stay and for 30 days following, at least in the case of the preventable readmission measure.

However, we have concerns about the use of readmission measures for SNFs, as well as hospitals. The sickest individuals are most likely to be readmitted, but they are also the most likely to die. Persons who die cannot be readmitted and are excluded from the readmission measure. Therefore, hospitals and SNFs with excessive mortality rates may have lower readmission rates. We are concerned that SNF readmission measures could create incentives for SNFs to delay necessary and appropriate hospital care to avoid including readmissions in their performance scores. We note that readmission measures only count inpatient admissions, not emergency room (ER) visits. Thus, we suggest including ER visits, as well as inpatient readmissions, in the measure. We acknowledge there is an existing quality measure for ER visits for short-stay nursing facility residents. However, it may be more easily understood by beneficiaries and their family caregivers to have one readmissions measure that captures all hospital visits – including unplanned inpatient and ER visits – throughout their SNF stay and for 30 days following discharge.

We support the required Discharge to Community measure in the SNF QRP, as most older adults want to live independently in their homes and communities. However, like the readmission measure, we suggest that the discharge to community measure include ER visits. As CMS will already be collecting all the data necessary to compute this, adding ER visits would not impose an administrative burden on SNFs or hospitals.

More broadly regarding the SNF VBP program, some skilled nursing facilities will be receiving reduced Medicare payments. AARP urges CMS to closely monitor the impact of the SNF VBP program on quality of care and quality of life in nursing homes for both short-stay and long-stay residents. If CMS and/or states observe that the SNF VBP program has adverse impacts on quality, they should take appropriate action to help ensure quality. Based on data once the program is implemented, we also encourage CMS to suggest any legislative or regulatory changes that might be needed to address issues if they arise once the program is implemented.

SNF QRP: Quality Measure Proposed for FY 2020 Payment Determination and Subsequent Years

AARP commends CMS for proposing a new quality measure for payments beginning in FY 2020 to address medication reconciliation as called for under the Improving

Medicare Post-Acute Care Transformation (IMPACT) Act. AARP strongly supports efforts to minimize preventable medication-related problems and encourage appropriate prescribing, monitoring, and safe use of medications. The proposed quality measure would assess whether post-acute care facilities were responsive to potential or actual clinically significant medication issues when such issues were identified. As noted in the proposal, this would include a drug regimen review to identify drug discrepancies that may lead to adverse drug events, which can occur during transfers from acute care facilities to post-acute care facilities and lead to unnecessary health care utilization and costs.

SNF QRP: Quality Measures and Measure Concepts under Consideration for Future Years

CMS solicits comments on the proposed quality measures for future years in the SNF QRP. CMS is developing a measure related to the IMPACT Act domain, accurately communicating the existence of and providing for the transfer of health information and care preferences of an individual to the individual, family caregiver of the individual, and providers of services furnishing items and services to the individual when the individual transitions. This is an important domain that recognizes the vital role of the individual, family caregiver, and providers in caring for the individual and communicating and sharing information among all these parties, including around care transitions. It also acknowledges the importance of knowing and communicating an individual's care preferences among all the parties, so they can be respected and acted upon. This domain provides an opportunity to measure person-and family centered care in skilled nursing facilities and at care transitions, as well as the coordination, communication, and team approach needed to effectively provide this care. It is hard to capture this domain in a single measure, unless it is a composite measure made up of multiple measures.

AARP appreciates and supports the idea of adding quality measures that include consumer reported experience of care and health status data. The proposed measure focusing on pain and four measures focusing on function that rely on data reported by the consumer may be helpful. In addition, AARP suggests that CMS include experience of care data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Nursing Home Surveys that examine resident and family members' experience of care. These are important data that would provide insights into whether resident care preferences were respected. We also appreciate the proposal to include a measure regarding the percent of SNF residents who newly received an antipsychotic medication, as inappropriate use of antipsychotic medications is a continuing problem among nursing home residents.

Person-and family-centered care is at the heart of this domain. Very often, smooth care transitions and successful discharge planning depends on the active involvement of family caregivers (defined broadly) who voluntarily provide support and assistance to their loved ones before, during, and after discharge. Once home, the family caregiver may be implementing a discharge plan or care plan so that the individual does not

return to the SNF or to a hospital unnecessarily. The individual may also be receiving home health care, so the family caregiver may also be coordinating care with a home health agency.

The assistance provided by family caregivers can also be complicated and demanding. In a national survey conducted by the AARP Public Policy Institute and the United Hospital Fund, almost half (46 percent) of family caregivers reported performing medical and nursing tasks for care recipients with multiple chronic physical and cognitive conditions.[1] These tasks include managing multiple medications, providing wound care, preparing food for special diets, using monitors, and operating specialized medical equipment. These tasks were in addition to the assistance they were already providing with bathing, dressing, eating, and other household tasks. Most caregivers said that they received little or no training to perform these medical and nursing tasks.

CMS recognized the important role that family caregivers play in discharge planning in last year's proposed rule revising the requirements for long-term care facilities (skilled nursing facilities and nursing facilities) to participate in Medicare and Medicaid (CMS-3260-P). The discharge planning process is required in §438.21(c)(2)(iv) of that proposed rule to "Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs." Given the important role family caregivers play in care transitions and the need to support them to help ensure quality outcomes and prevent unnecessary and costly care, AARP strongly urges CMS to include a quality measure or measures in this domain that measure:

- How often the SNF has clearly documented in the discharge summary and plan if the individual has a family caregiver(s) and their contact information (with the consent of the resident and family caregiver(s));
- How often this information is appropriately communicated to other providers of services furnishing items and services to the individual;
- How often the SNF has clearly documented if the family caregiver will be available to provide assistance to the resident under the care/discharge plan or post-discharge;
- How often prior to discharge the family caregiver was provided with or referred to supports they need to carry out their responsibilities post-discharge, including training to perform tasks that are part of the care/discharge plan (after determining a need for such supports prior to discharge); and
- Whether the SNF is willing to provide alternative times to meet to discuss the discharge plan with the individual (resident) and the family caregiver(s).

[1] [1] S. Reinhard., C. Levine, & S. Samis, *Home Alone: Family Caregivers Providing Complex Chronic Care* 1 (AARP PPI and United Hospital Fund, 2012), *available at* http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/home-alone-family-caregivers-providing-complex-chronic-care-rev-AARP-ppi-health.pdf.

We note services provided by family caregivers should only be included in the discharge plan if family caregivers have agreed to provide these services and have indicated their ability to carry out the actual tasks. In addition, family caregivers can also be vital to ensuring that the individual's care preferences are communicated and carried out. This is yet another reason they are critical to this domain of care and why there should be a measure(s) regarding SNF interaction with and support of family caregivers.

AARP appreciates the opportunity comment on this proposed rule and important quality measures. We urge CMS to address the concerns we raise and include our suggested improvements in the final rule to improve the quality of care and help ensure person-and family-centered care. If you have questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3770.

Sincerely,

David Certner
Legislative Council & Legislative Policy Director
Government Affairs