



601 E Street, NW | Washington, DC 20049  
202-434-2277 | 1-888-OUR-AARP | 1-888-687-2277 | TTY: 1-877-434-7598  
www.aarp.org | twitter: @aarp | facebook.com/aarp | youtube.com/aarp

June 21, 2018

Administrator Seema Verma  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1696-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Submitted electronically to: <http://www.regulations.gov>

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

Dear Administrator Verma:

AARP appreciates the opportunity to comment on this skilled nursing facility (SNF) payment proposed rule. Our comments will focus on the provisions regarding changes to the case-mix methodology in the SNF prospective payment system (PPS), the SNF Quality Reporting Program, and interoperability and electronic health information exchange.

AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, 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.

### **Case-Mix Classification Methodology in the SNF PPS**

As noted in our comments on the advance notice of proposed rulemaking (ANPRM) on changes to the case-mix methodology in Medicare's SNF PPS, we recognize that the current Part A SNF payment system, which uses Resource Utilization Groups (RUGs), incentivizes SNFs to overuse rehabilitation therapies (physical therapy, occupational

therapy, speech-language pathology) by paying more for residents receiving these services than for residents not receiving them. We appreciate that the proposed change to the SNF Patient-Driven Payment Model (PDPM) would base Part A SNF payment more on resident characteristics than the current RUGs system.

AARP remains troubled, however, that the complexity and magnitude of these changes could create financial incentives for SNFs to under-supply some services and limit care for some residents, particularly those who are older and have longer SNF stays, as shown by CMS' impact analysis.

CMS has made some efforts to address these issues in this proposed rule, but we remain concerned about whether these safeguards are sufficient to protect beneficiaries. AARP supports, for example, CMS' proposal to better track the amount of therapy provided to SNF residents. CMS proposes to add 18 therapy collection items to the PPS Discharge assessment and require providers to complete these items beginning October 1, 2019. While these data may help improve the system over a longer period of time, beneficiaries could suffer in the short-term if providers stint on care, and thus we encourage CMS to develop additional means to monitor these issues on a more real-time basis during the implementation of the PDPM. We also urge CMS to take additional appropriate steps to prevent adverse impacts on Medicare beneficiaries who need SNF care.

We understand that CMS' proposal that concurrent and group therapy combined should be limited to no more than 25 percent of a SNF resident's therapy minutes by discipline is intended to lead towards more efficient provision of care. However, we generally believe that individual therapy can best address a specific resident's care needs and any therapy changes should ensure that each individual resident has their therapy needs met. CMS proposes that when the amount of group and concurrent therapy exceeds 25 percent within a given therapy discipline, providers would receive a warning edit on their validation report that they are out of compliance. We remain concerned, however, that this limit does not ensure that beneficiaries are receiving the appropriate therapy to meet their specific needs. We would support additional real-time efforts, such as the warning edit, to monitor compliance and ensure that beneficiaries are receiving needed care. It is important to guard against stinting on care.

CMS also proposes to eliminate multiple periodic resident assessments and instead rely only on an initial 5-day admission assessment, a discharge assessment, and an Interim Payment Assessment (IPA), as needed, to capture significant clinical changes. As noted in our response to the ANPRM, AARP remains very concerned that the elimination of multiple periodic assessments could reduce the ability of CMS and surveyors to detect changes in the status and progress of SNF residents and reduce the availability of data on which to base future SNF payment adjustments. We urge CMS to retain existing assessments.

While the PDPM would increase reliance on resident characteristics, it would continue to categorize residents to some extent based on certain therapeutic interventions, such

as use of IV feeding and ventilator support. In doing so, CMS should work to ensure that payment aligns with needed care. SNFs should not have incentives to either artificially increase the use of these therapies without necessarily benefiting residents or stint on necessary therapies for residents. We urge CMS to make sure that any payment changes ensure necessary and quality SNF care for all SNF residents.

### **Proposed New Removal Factor for Previously Adopted SNF Quality Reporting Program Measures**

We oppose the adoption of the proposed new eighth factor for evaluating whether to remove a previously adopted quality measure; the proposed new factor is “the costs associated with a measure outweigh the benefits of its continued use in the program.” As described in the proposed rule, a variety of different costs could be considered under this criterion. While we understand the goal of ensuring that quality measures yield meaningful benefits, we do not support using the proposed new criteria to potentially remove an existing measure; the existing seven factors are sufficient to achieve this goal. With respect to the proposed new factor, it is difficult or impossible to measure the benefits to Medicare beneficiaries (such as good quality of care, timely care, good communication between providers and individuals and their family caregivers, and quality of life) using a dollar metric. Further, benefits accrue to beneficiaries, while costs are typically born by providers – these are not equivalent. The proposed new factor would open the door for providers to argue for dropping a measure they do not want to collect or report for various reasons (such as that it would raise their costs to avoid performing poorly on it), but which is important to beneficiary outcomes.

### **Request for Information on Promoting Interoperability Through CMS Patient Health and Safety Requirements for Hospitals and Other Providers**

AARP supports the continued promotion of electronic health information exchange and interoperability that is aimed at improving patient care by making medical records readily available to providers, patients, and their family caregivers, as appropriate. Electronic data exchange among hospitals, physicians, hospices, SNFs, and other post-acute care providers is especially important during care transitions when maintaining access to information relevant to the individual’s next phase of care is essential.

For individuals (and family caregivers, as appropriate) having information useful to manage their own care when they are not directly interacting with their care team (e.g., after an encounter) is a critical support that everyone needs, regardless of their condition or health status. Access to information electronically -- such as discharge summaries and test results -- greatly enhances opportunities to engage in one’s own care, by sharing information with providers, family caregivers, or other members of the individual’s care team, and to help them to better coordinate and manage their care needs. Under HIPAA privacy rules, health care providers must give individuals access, upon request, to their protected health information. People with the capacity to access their medical records and personal health information through patient portals or other electronic means should have the right and ability to do so without undue burden.

However, while AARP fully supports moving forward expeditiously on improved electronic access, many people will still need or prefer printed copies of their medical records or discharge/transfer summaries, and to have access by mail or fax, and CMS should ensure that this right continues. Not everyone has the technology for electronic access, and this is particularly true for many older Americans.

Use of requirements for SNF participation aimed at greater provider participation in electronic health information exchange should be considered carefully and should be based on a realistic assessment of costs to providers and reasonable timeframes for adoption. Given the potential to reduce Medicare beneficiary access to care, requirements for SNF participation may not be the best approach because the consequences of failure by a provider to meet the standard could be exclusion from the program. If this type of mandate is chosen, the specific requirements should be attainable by providers making a good faith effort and perhaps phased in over time. SNFs have not had the opportunity to participate in the financial incentives offered by what is now the Medicare and Medicaid Promoting Interoperability Program. Special circumstances of rural and low-volume providers should be taken into account. If imposed requirements are unattainable, the policy would not only fail to achieve the goal of improving electronic health information exchange, but could result in other unintended consequences.

AARP appreciates the opportunity to comment on this important proposed rule. It is vital for the SNF payment system to support necessary, quality care that meets individual resident needs and for CMS to help ensure that beneficiaries have quality measures and other information they need to receive quality care. If you have questions, please contact me or Rhonda Richards (rrichards@aarp.org) on our Government Affairs staff at 202-434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

David Certner  
Legislative Counsel & Legislative Policy Director  
Government Affairs