June 18, 2019

The Honorable Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1718-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; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2020

Dear Administrator Verma:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to comment on this Medicare skilled nursing facility (SNF) payment proposed rule. Our comments will focus on the proposal to allow group therapy to be with up to six residents instead of the current four residents; proposed quality measures; the request for information (RFI) on SNF Quality Reporting Program (QRP) quality measures, measure concepts, and standardized patient assessment data elements (SPADEs); and data collection and reporting on the impacts of the new SNF payment system changes that are effective October 1, 2019.

Defining Group Therapy

AARP does not support CMS’ proposal that could increase the size of a group therapy session by allowing allow one therapist or therapy assistant to treat as many as six residents at the same time in such a session. As described in the proposed rule, since the inception of the SNF PPS in July 1998, CMS has defined the number of residents engaging in group therapy to equal four, noting its long-held belief that individual therapists cannot adequately supervise large groups, and that groups of two or three do not offer sufficient opportunity for patients to interact and learn from each other. We urge CMS to keep the current group therapy definition.
We generally believe that individual therapy can best address a specific resident’s care needs, and as CMS considers changes to the therapy requirements for SNFs, its focus should be on ensuring that each individual resident has their therapy needs met. CMS has stated its own view that individual therapy is generally the best way to provide therapy because it is most tailored to the individual resident’s needs. AARP is pleased that CMS reiterates the requirement to document the choice of group therapy over individual or concurrent therapy for an individual resident, and that the SNF should include in the person’s plan of care an explicit justification for the use of group therapy, including at least how the prescribed type and amount of group therapy will meet the individual’s needs and assist the person in reaching the documented goals. However, more important is monitoring and enforcement of SNF compliance with the combined 25% limit on concurrent and group therapy as a share of each resident’s total therapy regimen, by discipline, during the resident’s Medicare-covered SNF stay. CMS should monitor and report on the extent to which the warning edit is triggered and consider putting an appropriate penalty in place to further assure compliance.

While we understand that in some cases individuals can have their therapy needs met within a larger group, we believe that CMS has been correct over the years in its concern about the difficulty of a therapist properly supervising more than the current standard of four individuals. In addition, the flexibility offered in the proposal to define a group to include from two to six residents would potentially allow other facility priorities to take precedence over the therapy needs of individual patients. The use of group therapy, which CMS notes has been low, could increase substantially under the proposal to the detriment of individual patients. CMS has acknowledged that SNFs may be incentivized under the PDPM to emphasize group and concurrent therapy in place of individual therapy. Again, we urge CMS to retain the current definition of group therapy and encourage monitoring of the volume of group and concurrent therapy versus individual therapy and the consideration of appropriate penalties for SNFs that violate that limit.

Proposed Quality Measures for the SNF Quality Reporting Program (SNF QRP)

AARP supports the proposed addition of two transfer of health information measures to the SNF QRP and other post-acute care provider quality reporting programs and encourages CMS to further strengthen one of these measures. The PAC measures “Transfer of Health Information to the Provider” and “Transfer of Health Information to the Patient” would assess the frequency with which the SNF provides a current reconciled medication list when a resident is discharged to another provider setting (and the information transferred to the provider) or home (information transferred to the resident, family or caregiver). As the review of the literature in the proposed rule indicates, proper transfer of health information and patient care preferences is critical to ensuring safe and effective transitions from one health care setting to another.

In particular, with respect to the Transfer of Information to the Patient measure, AARP notes the importance of providing the reconciled medication list to the family caregiver
(broadly defined), as appropriate. Very often, smooth care transitions and successful discharge planning depends on the active involvement of family caregivers who voluntarily provide support and assistance to their loved ones before, during, and after discharge. Once home, the family caregiver(s) may be implementing a discharge plan or care plan so that the individual does not return to the SNF or to a hospital unnecessarily. For this reason, giving the caregiver accurate and up-to-date information about the beneficiary’s medication list can help ensure compliance with needed prescriptions and serve as a patient safety measure, as patients are vulnerable to avoidable adverse drug events during care transitions resulting in unnecessary health care utilization and costs. The data element for this measure should be clear that if a Medicare beneficiary has a family caregiver that individual should receive the list if the beneficiary and family caregiver consent, even if it is also provided to the patient.

We also urge CMS to further strengthen the Transfer of Information to the Patient measure. While it is very important for the resident, family or caregiver to have the reconciled medication list, in some cases, simply providing the list may not be sufficient. We urge CMS to strengthen this measure to also include that the patient (resident), family, or caregiver be given a chance to ask questions about the medication list to ensure they understand it. Importantly, this could also help ensure that individuals correctly take their medications and avoid adverse events.

Request for Information on SNF QRP Measures, Measure Concepts, and Standardized Patient Assessment Data Elements (SPADEs)

Caregiver Status is identified as a possible standardized patient assessment data element (SPADE) for addition to the program in future years, and CMS seeks comment on its importance, relevance, appropriateness and applicability. AARP strongly supports adding a SPADE to the patient assessment instruments in all the post-acute settings that would identify whether the patient has a family caregiver and to identify that individual to the facility including contact information (with consent of the resident and the family caregiver). This would ensure that the provider is aware when a beneficiary has a caregiver, who may or may not be the next of kin. The caregiver may have information that is helpful to the provider in caring for the individual, and involving the caregiver during the discharge planning process can help the beneficiary make a smooth transition home or to the next provider setting. In addition, family caregivers can also be vital to ensuring that the individual’s care preferences are communicated and carried out. Creating a Caregiver Status SPADE would also allow for future development of one or more quality measures regarding SNF interaction with and support of family caregivers.

Standardized Patient Assessment Data Reporting Beginning with FY 2022

AARP supports the greater use of SPADEs to enable creation of quality measures that can be used across all the post-acute care settings, consistent with the IMPACT Act requirements. We are particularly pleased to see the proposal for a new category of SPADEs that would collect data on social determinants of health, including race,
ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation. In addition to potentially adding to the provider’s knowledge of the individual, when aggregated, this information will allow for greater understanding of the needs of vulnerable populations as well as permit the creation of tools to assess provider performance on quality metrics among different populations. CMS may also want to consider adding level of education to the data collected regarding social determinants of health.

All-Resident Data Reporting for the SNF QRP

AARP supports the proposal to require SNFs to report Minimum Data Set data on all residents, regardless of payer, beginning October 1, 2020. We agree that this approach would result in data that most accurately represents the quality of care provided in SNFs to Medicare residents.

Understanding the Impact of the Patient Driven Payment Model (PDPM)

AARP urges that CMS establish a system of early warning/near real-time data collection and reporting to assess the impact of the PDPM on SNF residents. We also urge CMS to make publicly available information and analysis that shows how the PDPM is impacting SNF residents. As expressed in past comments, we remain concerned that the PDPM, which will begin in FY 2020, could create financial incentives for SNFs to under-supply some services and to limit care for some residents, particularly those who are older and have longer SNF stays. We believe it is particularly important to monitor these issues during initial implementation of the PDPM in ways that will allow CMS to quickly understand and address emerging problems affecting SNF residents.

AARP appreciates the opportunity to comment on this important proposed rule. It is important to continue to recognize that individual therapy is generally the best way to address the individual resident’s needs, and for CMS to monitor in real time the impact of the PDPM in order to quickly address issues that may arise to the detriment of Medicare beneficiaries. 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 Counsel & Legislative Policy Director
Government Affairs