August 24, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1686-ANPRM
P.O. Box 8016
Baltimore, MD 21244-8016

Electronic submission via www.regulations.gov

RE: CMS-1686-ANPRM. Advance Notice of Proposed Rulemaking with Comment. Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Revisions to Case-Mix Methodology, 82 Fed.Reg.20980 (May 4, 2017)

Dear Administrator Verma:

The New Jersey Hospital Association (NJHA) represents more than 400 healthcare providers across the continuum of care. More than 100 of our members are skilled nursing facilities (SNF); they are a diverse group of SNFs that includes for-profit and non-profit providers, as well as hospital-based SNFs.

NJHA appreciates the effort the Centers for Medicare and Medicaid Services (CMS) has put into improving the SNF PPS, and we support the overall goal. However, we are concerned that the resident classification system (RCS-1) as currently outlined would not achieve the goals of maintaining an easily understood payment system, assuring appropriate access to needed rehabilitation services and more accurately paying SNFs for services provided. NJHA fully supports the direction CMS is pursuing to base SNF payments on resident characteristics, a more person-centered approach.

Maintaining an Easily Understood Payment System

There is always a need to strike a balance in the development of payment systems between accuracy, precision and understandability. NJHA supports CMS' goal of having SNF payments

accurately reflect the cost of care for individuals. However, it is critical that SNF providers are able to both understand and explain how the payment system is structured. The RCS-1 is much more complex than the RUGS-IV system once you get past the initial foundation of basing payments on individual characteristics. Generating the component case-mix indices is not easily understood or explained.

NJHA urges CMS to examine ways to strike a better balance without sacrificing the integrity of the model in terms of its ability to generate accurate payments.

Assuring Access to Needed Therapy Services

NJHA supports CMS' goal to remedy the practice of delivering "therapy to beneficiaries based on financial considerations, rather than the most effective course of treatment for beneficiaries." Based on the analysis of impact in the technical report, we are concerned that the RCS-1 model may over-correct for prior "bad behavior." The incentives are clearly shifting toward medical intensity/complexity, and as we have seen in the past, providers alter behavior in response to incentives within the system. While it may be impossible to account for such changes in behavior within the model, we believe it is important for CMS to protect beneficiaries who truly need rehabilitation therapy so that they are not denied access to therapy due to payment model incentives. In addition, NJHA is interested in learning how CMS views the *Jimmo* settlement within the context of RCS-1; does the beneficiary's right to access to maintenance therapy fall solely within the realm of restorative nursing, or is there a need and a role for rehabilitation therapy professionals in delivery of maintenance therapy?

Payment Accuracy

NJHA agrees that it is essential for the SNF PPS payment system to reflect the individual's actual care needs, and that the payment derived from the model should be based on objective data about the individual's characteristics, rather than on service-based metrics. Inherent to the MDS assessment process, regardless of the instructions and definitions provided in the RAI manual, is the fact that clinical judgement and opinion enter into identifying the individual's characteristics.

We specifically appreciate the RCS-1 system's focus on improving payment accuracy for clinically complex patients who are most commonly treated in hospital-based SNFs. Hospital-based SNFs embody many of the characteristics that policymakers have tried to emphasize for all SNFs. Notably, hospital-based SNFs typically have far fewer high intensity therapy RUGs than a typical SNF, and their average lengths of stay and readmission to hospital rates tend to be lower even though the medical complexity of their patients is higher.

In addition, we are pleased that the RCS-1 would include a non-therapy ancillary (NTA) component since these services play a crucial role in caring for clinically complex patients.

One of our concerns is that the RCS-1 model relies upon claims data from 2014 and does not account for the considerable influences that the voluntary bundled payment for care

improvement (BPCI) program, accountable care organizations, Medicare Advantage contracts and the comprehensive joint replacement (CJR) bundling program have had on SNF and other provider practices. The last three years have been a time of extraordinary change that is occurring at a pace the field hasn't seen in recent memory. In addition, the IMPACT Act requirements and the implementation of the SNF value-based payment program will bring about even more improvements and changes. NJHA urges CMS to consider waiting for more recent and relevant data, especially with regard to claims payments, to become available before proposing the RCS-1 for implementation. Thus far, CMS has not indicated how the agency believes the proposed RCS-1 will interact with and fit within the broader policy and payment reform environment. Further, NJHA believes that any revised payment system must be flexible and nimble enough to be updated and rebased so that it continues to accurately reflect the individuals being served in SNFs and the changes in the relationships between hospitals, SNFs and other post-acute providers. This flexibility needs to be part of any system's structure before implementation can be achieved.

Lastly, the RCS-1 model does not appear to reflect any of the new or revised requirements finalized in the Oct. 2016 Requirements of Participation (RoPs) for long term care. Some of the requirements such as those related to infection control and trauma-informed care need to be addressed in a revised payment system.

Implementation Plan and Transition

NJHA is concerned that the ANPRM primarily provides a technical description of the model's design and offers little detail on how the system would be operationalized and overseen by CMS. We believe CMS must consider the practical challenges SNFs will face in implementing a new payment system at the same time that they are also adjusting to the new RoPs, the emergency preparedness rules, SNF VBP and the revised survey process. The shift away from therapy being a revenue center to being a cost center is significant. As currently designed, RCS-1 yields more than 300,000 possible payment groups. Practically speaking, SNFs need an operationally viable and reliable method to assess patient needs and project payment so they can determine whether a patient is appropriate for SNF admission.

NJHA believes CMS must provide clear guidance and support to make certain that SNFs make the transition successfully. SNFs will need to have the appropriate information technology infrastructure and vendor support to transition to a new payment model; this requires financial and human resources. Further, these transitions take a substantial amount of time to make sure that providers and vendors are ready, have time to adequately train staff, revise and optimize work flows, update systems and make other process changes required. CMS plays a critical role in offering proactive provider and vendor education and assistance.

ICD-10 Coding

NJHA is very concerned about the implications of greater reliance on ICD-10 coding as part of the resident classification process. The proposal states that certain ICD-10 diagnostic codes that appear in MDS I8000 will be used to help assign the individual to a RCS-1 category. The SNF provider community differs significantly from the acute care hospital community in terms of the level of coding expertise that exists. Therefore, the accuracy and reliability of coding by SNFs is a concern. NJHA believes it will be essential for CMS to elevate the importance of appropriate training of SNF staff and coding experts with respect to ICD-10 coding for SNFs.

Further, CMS appears to presume that the ICD-10 codes that would be included in the transfer documents from the acute care hospital are final and accurate. This is not factually correct. Hospital coders assign the final diagnostic code(s) after a patient is discharged from the hospital and after all clinical documentation has been completed and reviewed. This can take several days after the patient is discharged. The information the hospital sends to the SNF precedes the coding of the record for hospital reimbursement purposes and does not necessarily reflect the final diagnoses. SNFs code upon admission to initiate the billing process and to have codes available for completion of the MDS and ordering of diagnostic tests, etc. Ultimately, the final diagnostic codes used for hospital billing and DRG assignment are often not readily available to the SNF.

NJHA appreciates the opportunity to comment on the ANPRM. We look forward to continuing to work with CMS on improvements to the SNF PPS. If you have any questions about our comments, please contact me at 609-275-4102 or via email at tedelstein@njha.com.

Sincerely,

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