AHCA
AMERICAN HEALTH CARE ASSOCIATION

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

May 13, 2016

Center for Medicare and Medicaid Innovation
7500 Security Boulevard
Baltimore, MD 21244

RE: Comments on The Center for Medicare and Medicaid Innovation's (CMMI) Request for Information on Concepts for Regional Multi-Payer Prospective Budgets

To Whom It May Concern:

The American Health Care Association (AHCA) represents more than 10,000 non-profit and proprietary skilled nursing facilities (SNF). By delivering solutions for quality care, AHCA aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care (LTPAC) in our member facilities each day.

As the voice in Washington for the vast majority of America's skilled nursing facilities, it is the responsibility of AHCA to ensure that our profession's position on key legislation and proposed regulations is communicated to the appropriate governmental bodies. This document summarizes AHCA's comments regarding the multi-payer Request for Information. In short, the Association respects the Centers for Medicare and Medicaid Innovation's efforts to modernize Medicare and Medicaid. However, we remain concerned about the omission of downstream providers, such as post-acute and long-term care providers, in demonstrations in pilots. Such providers provide services critical to ensure restoration of function and the on-going health and wellbeing of Medicare beneficiaries.

Embracing PAC Payment and Quality Modernization

Since 1965, the Medicare program has adapted and evolved to better serve patients and their families. A key component of these changes is how Medicare reimburses for services provided for patients. To help curb costs and cap spending, Medicare payment has evolved from a fee-for-service (FFS) approach to the current prospective payment system — a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. Now, Medicare has reached a pivotal point driven by an increasing older adult population which will be in need of more health care services. Medicare should adapt to meet the needs of Medicare beneficiaries and providers who deliver critical services, including post-acute care (PAC). New payment approaches will be implemented that reward providers for quality and value. AHCA supports the implementation of a value-based purchasing (VBP) program for skilled

AHCA
AMERICAN HEALTH CARE ASSOCIATION

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

nursing facilities, and we look forward to working with CMS to develop an approach that provides cost savings, ensures quality care for beneficiaries, and is fair to providers.

To ensure that value and quality go hand-in-hand under new payment approaches, AHCA has implemented a Quality Initiative for its members to raise the bar in care delivery and set measurable goals for quality improvement in key areas. This year, AHCA has broadened its Quality Initiative to further improve the quality of care in America's skilled nursing care centers. While avoiding setting a standard of care, the expansion will challenge members to apply the Baldrige Performance Excellence Framework to meet measurable targets in eight areas with a focus on three key priorities: improvements in organizational success, short-stay/post-acute care, and long-term/dementia care. These areas are aligned with the CMS Quality Assurance/Performance Improvement (QAPI) program, and other federal activities such as Five-Star and the Improving Medicare Post-Acute Care Transformation (IMPACT) Act.

Evolving SNF Statutory and Regulatory Environment

AHCA recognizes that CMMI faces unique challenges with implementing each demonstration. For any demonstration, CMMI should consider the combined efforts of new payment approaches, value-based purchasing, health information exchange and quality reporting which all impact SNFs. Although not new for other Medicare providers, this is the first time these components have been cumulatively implemented upon SNFs.

Specifically, going forward, Section 215 of the Protecting Access to Medicare Act of 2014 (PAMA) added new subsections (g) and (h) to section 1888 of the Social Security Act (Act). The new subsection 1888(h) authorizes establishing a Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program beginning with FY 2019 under which value-based incentive payments are made to SNFs in a fiscal year based on performance. The incentive payments will be paid from a pool of dollars accrued through a 2% withhold applied to all SNFs. Based on their rehospitalization performance, SNFs may or may not earn back none, some, all or more than the 2% that was withheld.

Additionally, the Improving Medicare Post-Acute Care Transformation Act of 2014 (P.L. 113-185) (IMPACT Act), enacted on October 6, 2014, requires the implementation of an array of SNF quality reporting elements. Beginning with FY 2018, the Act requires SNFs that fail to submit required quality data to CMS under the SNF Quality Reporting Program (SNF-QRP) to have their annual updates reduced by two percentage points. AHCA supported both PAMA and the IMPACT Act and will continue to support quality efforts through the Association's Quality Initiative, collaborative work with CMS, and collaboration with Congress.

AHCA recognizes moving from volume to value is a Department of Health and Human Services priority both under the Affordable Care Act as well as under the Secretary's goals for moving from FFS to alternative payment methods as well as value-based purchasing. However, moving from volume to value payment methodologies combined with eroding fee-for-service (FFS) payments make it essential that the remaining FFS payments are as accurate as possible. Regarding eroding FFS payments, current Medicare Advantage (MA) enrollment, nation-wide now is approximately 33% of Medicare beneficiaries while an additional 17% of Medicare beneficiaries are attributed to some form of a Medicare Accountable Care Organization (ACO). And, AHCA research indicates continued growth in MA enrollment, ACO attribution, and enrollment of duals in likely state-based Medicare-Medicaid integration programs.

RFI Detailed Comments

The remainder of this transmittal provides an overview of our ideas which specifically pertain to this solicitation for information. We have a number of other questions and suggestions but, for now, offer these five high priority items.

AHCA
AMERICAN HEALTH CARE ASSOCIATION

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

Comment 1: CMMI should broadly expand access to historical, beneficiary-level claims data to all providers who are expected to contribute to the cost savings and quality improvement efforts of demonstration initiatives.

AHCA appreciates the CMS' recent and ongoing efforts to improve data transparency across the health care system, and in particular its advancements and improvements in providing data to participants of demonstration initiatives. Having access to comprehensive, robust claims data, both raw and aggregated, is absolutely essential to providers who wish to implement quality improvement initiatives within the time frames established by most of these programs. As such, CMS should expand, not restrict, the potential audience and recipients of comprehensive claims data and reports. AHCA strongly believes that CMS should provide access to full, beneficiary-level claims data, as well as aggregated reports, to any Medicare-certified provider who would be expected to make operational efficiencies and quality improvements related to the demonstration. At a minimum, CMS should make this data available to any post-acute care provider who operates in a region participating in the demonstration; CMS should not restrict data access to hospitals, even if they are the only defined "at-risk" entity under the model.

CMS currently provides detailed claims data and aggregated reports to participants of CMMI demonstration models, such as the Bundled Payments for Care Improvement (BPCI) initiative and the Comprehensive Care for Joint Replacement (CJR) demonstration. However, AHCA believes that, in these instances, CMS' definition of "participant" is too narrow. CMS typically has restricted access to full claims data and aggregated reports to providers or other entities who are required to bear risk under the given model. Under CJR, the acute care hospital is the only *required* at-risk entity, and therefore CMS guarantees data access only to those providers. However, AHCA believes it was CMS' intent under CJR for different provider types to collaborate in new and innovative ways, and to engage in risk-sharing arrangements if desired. CMS clearly expects non-hospital provider types, and in particular post-acute care (PAC) providers, to implement quality improvement initiatives and engage in care redesign. AHCA maintains that if CMS expects PAC providers to engage in the same level of care redesign and quality improvement as its defined "participants," it should also allow them the same access to the data necessary to implement such improvements.

In the RFI, CMS states that it "believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers)…" AHCA urges CMS to abandon the presumption that just because hospitals are allowed to share certain data and information with PAC providers that they do so freely. In AHCA members' experience, while there are examples of hospitals willing to share information with collaborating PAC providers, it is more often the case that hospitals withhold or restrict PAC provider access to vital claims data and information. There are likely many reasons for this behavior, not the least of which is the inherent financial value of the data, the instinct among providers to guard a valuable resource, and perhaps a misinterpretation of what types of data sharing are allowable under HIPAA regulations.

Comment #2: CMMI should provide more opportunities for skilled nursing providers to engage in risk-bearing arrangements.

AHCA encourages CMMI to explore testing non-hospital-centric models of provider risk-bearing as part of this demonstration, to allow additional opportunities for PAC providers to engage in risk-bearing activities. In the majority of the current risk-bearing models CMMI is testing, the hospital is the defined risk-bearing entity. AHCA understands that hospital providers are the most likely entity in a market to be in a position to bear risk. We also recognize that many skilled nursing centers are small or independently owned entities and would likely not succeed under a mandatory risk-bearing model. However, for those skilled nursing providers who are ready to engage in more robust risk-sharing arrangements, AHCA believes

AHCA
AMERICAN HEALTH CARE ASSOCIATION

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

CMMI should provide opportunities for them to do so. Such opportunities should not be left to the discretion of acute care hospitals.

Comment #3: CMMI should limit the ability of third-party organizations to bear financial risk on behalf of providers, similar to how the CJR demonstration allows for such arrangements.

AHCA has provided CMMI extensive feedback in the past on the issues and challenges associated with third-party conveners who directly bear risk on behalf of providers, particularly within the BPCI demonstration. We also appreciate that CMMI seems to have addressed many of our concerns in their publication of the CJR final rule, which limits the role third-party entities may play in risk-sharing, but still allows providers to contract for their services in other ways. AHCA believes that the fundamental problem with allowing third-party conveners to directly bear risk for total episode spending is that it invariably siphons funds away from direct patient care to fund the operation and profit of the convening organization. We strongly believe that these funds would be better used by providers to implement quality improvements and delivery system reforms necessary under a risk-bearing model. AHCA recommends that CMMI replicate the approach and policies established in the CJR final rule with regard to how third-party non-provider organizations may share in financial risk.

Comment #4: The demonstration should fully waive the SNF 3-day inpatient qualifying stay for coverage of skilled nursing care, to include the ability to directly admit beneficiaries to the SNF.

AHCA is supportive of efforts to test a waiver of the 3-day qualifying inpatient stay requirement for coverage of skilled nursing services, but we continue to have strong concerns that tying the waiver to a facility's rating on Nursing Home Compare will limit beneficiary access to skilled nursing care, particularly those with complex and chronic conditions. As CMS is aware, patients, families and caregivers must consider multiple factors when deciding where to seek post-acute care when it is needed. While we understand that CMS must create incentives for beneficiaries to seek care from efficient, high-quality providers, we also maintain that equal consideration also must be given to the non-clinical factors that go into the decision-making process, such as the availability of social supports and proximity to home and family.

AHCA understands that current demonstrations do not directly tie *participation* in the model to a facility's Five Star rating; however, we maintain that hospitals have a strong desire to utilize the waiver and will develop their skilled nursing networks only with facilities who have 3 or more stars. The following is an excerpt of our comments to CMMI on the CJR proposed rule:

> "Since the Five Star rating system is updated on a monthly basis, it is possible that a SNF's rating fluctuates every month. Analyzing data for two-year period (prior to the February 2015 rebasing of Five Star), we observe a 15% chance that a SNF who is rated 3 stars or higher will drop below 3 stars in the following 12 months. Not only does this level of fluctuation impact beneficiary choice of provider, but it also will make implementation of the program logistically challenging for hospitals as they try to establish a network of exclusive 3-star-or-higher SNFs. Although CMS states that the waiver will be honored based on the SNF's status at the time of discharge, hospitals may operate on information that is a month or more old, which could result in beneficiaries inadvertently admitted to what the referring hospital believed to be a 3-star or greater SNF to only find that it dropped to a 2-star. If the SNF does not meet the criteria, the stay would not be covered and the beneficiary could be financially liable for their stay. And finally, we suspect that hospitals will drop SNFs from their networks because of a drop in Five Star score despite the fact that nearly half could quickly regain a 3-star or greater rating. We anticipate this

AHCA
AMERICAN HEALTH CARE ASSOCIATION

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

fluctuation will create unintended, unnecessary restrictions in beneficiary choice of provider, even if that provider becomes eligible for the waiver."

AHCA also believes that models which place the hospital as the sole risk-bearing entity inherently limit the ability of CMS to realize the cost efficiencies of reducing the number of inpatient admissions. We continually hear from providers about the challenges associated with "balancing" fee-for-service business lines with alternative payment models. Because hospitals currently testing risk-bearing models are still being paid primarily under fee-for-service, they continue to have a strong financial incentive to increase inpatient volumes and, in our members' experience, are less willing to explore models where downstream PAC providers could be used as a less-costly alternative to the hospital. Indeed, even though providers participating in the BPCI and CJR programs may waive the 3-day stay requirement, these models require an inpatient admission to trigger the episode. AHCA believes CMMI has a unique opportunity in this model to test innovative approaches to using post-acute care providers as a high-quality, low-cost alternative to an inpatient admission.

Comment #5: The demonstration must consider the downstream implications of such an arrangement particularly on labor and wage indices.

AHCA has long believed that use of a hospital wage index as a proxy for SNF wage indices without adjustment is inappropriate and inaccurate. Over the years, the Association has repeatedly highlighted this concern. In turn, the Centers for Medicare and Medicaid Services (CMS) has indicated SNF data has been unreliable for the purpose of developing a SNF-specific wage index. This year we have developed a new approach which filters hospital wage index data to make such information more applicable to actual SNF labor costs.

Illustrative of how challenging the current arrangement is, in fiscal year 2016, of the 89 counties with more than a 15% fluctuation in the SNF wage index due to hospital changes, three counties had significant decreases of 19%, 22%, and 32%, respectively. Our research on these counties revealed issues with hospital non-submission of data or serious issues with hospital data. To that end, SNFs have been actively engaged in working with the acute care sector in many of these areas across the country on this issue. This year, we greatly are concerned about emerging trends associated with hospital acquisition of outpatient clinics and physician group practices which further dilute the wage index for SNFs. In terms of SNF reimbursement, 70% is driven by labor costs making accurate wage index calculations critical in light of the myriad of changes noted above. We urge CMMI to consider hospital wage index impacts on SNFs in this potential demonstration and others.

Conclusion

We hope these comments are helpful and respectfully request a meeting with the CMMI team working on this effort. In addition to AHCA staff, we propose bringing representatives from the Maryland provider community so CMMI staff may hear directly from post-acute and long-term care providers on their experiences. Please contact Mike Cheek at mcheek@ahca.org to schedule a time to meet. Thank you for your valuable time and consideration.

AMERICAN HEALTH CARE ASSOCIATION

1201 L Street, NW, Washington, DC 20005
T: 202-842-4444
F: 202-842-3860
www.ahca.org

Sincerely,

[Transmitted Electronically]

Michael W. Cheek
Senior Vice President
Reimbursement Policy & Legal Affairs