Topic 1: **Proposed Skilled Nursing Facility Payment System Revision**

AHCA Request: **Drop Acumen Proposal and Develop a Proposal which Better Aligns with the IMPACT Act-Mandated Unified, Cross Post-Acute Care Payment System**

Why may CMS believe a change to the SNF Medicare PPS is necessary?

1. The current system is too complex – it uses 792 data cells to construct payment.
2. The current system does not align well with current policy directions of CMS/CMMI.
3. Payment within the current system is overly linked to volume of services delivered –especially with respect to therapy - instead of patient characteristics.
4. There is a need to better align resource use & payment for Non-Therapy Ancillary Services (NTAS).
5. Quality and outcomes, with the exception of hospital readmission, are not tied to payment in the current system.

What may be CMS' policy objectives for SNF PPS Reform?

1. Tie payment to patient characteristics
2. Pay for value instead of volume – especially with respect to therapy services
3. Move toward implementation of IMPACT Act requirements
4. Reduce access barriers for beneficiaries with high cost NTAS needs
5. Move toward implementation of a unified post-acute care (PAC) payment model
6. Make the payment system simpler and more transparent
7. Ensure that the payment system aligns with new Alternative Payment Models including Accountable Care Organizations (ACOs) and Bundled Payments (BPCI, CJR & EPMs)

Where do we believe the Acumen proposal falls short?

1. **The historical data on which Acumen relied to build and model their proposal is flawed**

    a. SNF charges and cost to charge ratios are an artifact of an old cost based payment system, are inconsistent across providers and frequently contain values that are faulty.

    b. Ancillary cost to charge data used by Acumen was not reflective of all patients served by the facility (many services are billed to Part B or Part D) and often the coding (based on broad revenue codes) are only appropriate for establishing relative costs of large service bundles. This is appropriate in the

hospital IPPS from which this methodology is derived – but not for evaluating a single service category (such as Speech Therapy) as is being done in the Acumen proposal.

c. Acumen was instructed to rely on existing data regardless of quality, reliability or validity. The patient characteristic data used by the researchers can be shown to be unreliable and misleading. Such flaws in the data result in a virtual randomization of payment because neither the underlying patient characteristics in the base period or the related cost distinctions (some of which are made using data from a period other than the base period - such as STRIVE data weights) are accurate.

2. There is no policy consideration related to high cost "outlier" services or low volume providers.

a. The proposed system –due to the lack of an outlier policy - creates a disincentive to admit beneficiaries with known high cost NTAS thus creating potential access issues. This situation is only exacerbated if the same beneficiary happens to also have clinical conditions (such as dementia) that are likely to result in longer than average lengths of stay. CMS is assuming its patient characteristics approach will address this but flawed data and methods raise serious questions.

b. CMS and its contractor admitted to TEP participants that they expect SNFs to be overpaid for some Medicare patients and underpaid for others. They expected that SNFs would be able to manage these risks over their patient population in the same manner as Medicare Advantage plan sponsors (large insurance companies with tens or hundreds of thousands of covered lives) manage their risks. This is a very concerning assumption given that 50% of the SNFs in the country have fewer than 75 admissions per year (6.3 per month). Volumes this low will inadvertently result in a significant number of SNFs having a disproportionate number of beneficiary admissions on which they are either – perhaps significantly - overpaid or underpaid. Small providers with low volumes cannot take those types of financial risks with one of the few payers that has historically allowed for a positive financial margin.

3. The system as constructed and proposed cannot be implemented by the average provider in general and not likely by any provider before October of 2017 or by October of 2018.

a. This proposed SNF payment system has a potential of 247,680 distinct clinical categories. Each of which has its own criteria, payment rate, length of stay algorithm and set of building blocks. As a point of comparison the acute care inpatient hospital MS-DRG system has only 757 total classifications. As another point of reference there are only 75,625 valid ICD-10-CM/PCS (diagnosis) / (procedure) codes for 2017.

b. The system utilizes data for classification purposes that is likely to be clinically relevant to the SNF caregivers, but that is not known or available to the SNF prior to or at the time of admission or treatment & may not even be available prior to the patient's SNF discharge.

c. Our organization has attempted to build a clinical classification and revenue forecasting model based on the Acumen reports to the TEP from November/December 2016. We conducted this exercise out of caution just in case the FFY 2018 SNF Medicare PPS Proposed Rule included a transition to the Acumen payment model effective on October 1, 2017. What we learned from this exercise is that we are able to calculate rates for all 247,680 clinical groups. However, it was not possible for us to develop

a methodology to code our existing or past patients into those groups because we did not have the requisite data to do so. Therefore the profession cannot simulate the impacts based upon what CMS or its contractor has shared to-date.

d. It would be extraordinarily challenging to even implement a system such as the Acumen proposal by October 1, 2018 even if began today and we already had all the rules and software in hand and hand done all the requisite training of all our clinical and billing staffs. We make this statement simply as a matter of business process. Most of our members have financial obligations of one form or another be they to public shareholders, mortgage lenders, landlords or working capital lenders. These lenders require regular financial reporting and development of at least annual budgeting. If the Acumen system is proposed for implementation effective either October 1, 2017 or 2018, they would be unable to estimate revenue for the 4th quarter of 2018 in the summer of 2017 due to the inability to mock up a patient population profile based on existing/prior patients served relative to the Acumen proposal.

4. **The Acumen research is silent with respect to quality improvement. However, we do know that the IMPACT Act and its requirements were considered to be "outside the scope" of their engagement." There was no coordination with CMS quality staff.**

5. **Acumen has noted that the funding necessary to create the NTAS rate component will be taken from the nursing component however they, nor, CMS, have been able to specific how much funding would be moved to NTAS. We fear changes in the nursing component could exacerbate the ever increasing shortage of skilled (RN & LPN) personnel particularly in light of state federal minimum wage laws.**

6. **The proposed system creates unintended consequences creating incentives to avoid caring for patients with risk for high costs of care which is the antithesis of the overall revision goal. CMS should consider a targeted NTAS outlier policy perhaps along the lines of the one developed by Acumen in 2012 to which stakeholders commented and suggested somewhat minor improvements. AHCA largely supported the 2012 concept.**

We are also concerned by the lack of methodological transparency during the design phase of the payment system. The methods are discussed only at a high level and the rationale for the methods is entirely absent. AHCA has asked repeated for more detail with no follow up. Data quality issues are dismissed due to direction Scope of Work direction to use what is readily available. No technical explanation is provided regarding trimming or cleaning of data. The fit of statistical methods to data, given the non-existent explanation of data quality evaluation is not discussed anywhere. The approach to this reform proposal is, therefore, insufficiently transparent to engage in discussion of meaningful improvements, and the research team has not interacted with the TEPs and with stakeholders with any form of

accountability beyond reporting their results. This lack of transparency has also made it impossible for researchers to replicate the methodology on behalf of stakeholders.

Topic 2: SNF Wage Index

Request: Beginning trimming hospital data to more appropriately match post-acute care labor mix in FY18.

SNF FYE 2012 and FYE 2014 Cost Reporting and Wage Index Impacts

	FYE 2012	FYE 2013
Number of SNF Cost Reports in CMS HCRIS PUF	14,638	14,251
Number of SNF Cost Reports in CMS HCRIS PUF with No Data Reported on Worksheet S-3 Part V	1,252	245
Number of SNF Cost Reports in CMS HCRIS PUF with any Occupational Class (*) having an Average Wage Rate per Hour of < the federal minimum wage rate	254	165
Number of SNF Cost Reports in CMS HCRIS PUF with any Occupational Class having an Average Wage Rate per Hour of > $100.00	636	711
Number of SNF Cost Reports in the CMS HCRIS PUF after "trimming" for the above data anomalies	12,517	13,142
Percentage of SNF Cost Reports with "Reliable" data based on the above "trimming"	86%	92%
# of CBSAs with a SNF Wage Index that would have changed by > +/- 15% when moving from 2012 data to 2013 data		2.0%
# of SNFs in these affected CBSAs		56
# of CBSAs with a SNF Wage Index that would have changed by > +/- 10% when moving from 2012 data to 2013 data		4.4%
# of SNFs in these affected CBSAs		113
# of CBSAs with a SNF Wage Index that would have changed by > +/- 5% when moving from 2012 data to 2013 data		21.9%
# of SNFs in these affected CBSAs		1,012
# of CBSAs with a SNF Wage Index that differs from the 2016 Hospital Wage Index by > +/- 15%		24.1%
# of SNFs in these affected CBSAs		2,090
# of CBSAs with a SNF Wage Index that differs from the 2016 Hospital Wage Index by > +/- 10%		42.3%
# of SNFs in these affected CBSAs		3,883
# of CBSAs with a SNF Wage Index that differs from the 2016 Hospital Wage Index by > +/- 5%		69.0%
# of SNFs in these affected CBSAs		7,251

(*) RNs, LPNs, CNAs, Physical Therapist, PT Assistant, PT Aide, Occupational Therapist, OT Assistant, OT Aide, Speech Therapist, Respiratory Therapist; note certain additional staff categories are included in our prototype SNF wage index, detailed below.

Since the inception of the Medicare SNF PPS in 1998, the area wage index calculated for the hospital Inpatient Prospective Payment System (IPPS) also has been applied to the SNF PPS. Wage index values are assigned to Core-Based Statistical Areas (CBSAs) as determined by the U.S. Census Bureau and represent the hourly wage amount for all Medicare certified acute care hospitals in a designated CBSA divided by the national hourly wage amount for all Medicare certified acute care hospitals. Misstatement of an individual hospital's data can contribute to an erroneous wage index for an entire CBSA and impact other providers, including SNFs.

Depending on the SNF's assigned CBSA, the area wage index is applied to the labor-related portion of the SNF PPS rate, or Resource Utilization Group (RUG) rate, and added to the non-labor related portion of the rate. Since the labor-related portion of the rate is often close to 70 percent of the total RUG rate, the wage index has a significant impact on the final RUG rates for each CBSA and, of course, each SNF. An area wage index less than a 1.00 can result in a PPS rate that is below the full federal rate as published in the Federal Register and is meant to indicate that an area's wages are lower than the national average.

AHCA has long advocated for establishment of a SNF-specific wage index based upon SNF-specific labor data from SNF cost reports. Every year, we become more convinced that use of aggregate hospital wage and benefit data is an inaccurate and inappropriate proxy for computing SNF wage indices. And over the years, the Association has repeatedly highlighted this concern. In turn, CMS has indicated SNF data is unreliable for a SNF-specific wage index and that CMS does not have the manpower to audit SNF labor data.

We appreciate CMS' comments indicating willingness to explore this method but strongly believe they should accelerate the process to more appropriately adjust for wages in post-acute care settings.

Summary of AHCA/NCAL Recommendations and Requests

- Trim hospital wage data to exclude certain job categories that do not exist in the SNF environment so it is more appropriate for developing the SNF wage index in the FY18 NPRM.
- Phase in implementation of the new methodology over a three- to five-year period.
- Apply a 5 percent cap to wage index fluctuations (positive or negative) during the phase-in period.