American Association on Health & Disability

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AAHD - Dedicated to better health for people with disabilities through health promotion and wellness

LAKESHORE

June 25, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal to Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020.

CMS–1679–P
RIN 0938–AS96

Submitted electronically: http://www.regulations.gov

Dear Administrator Verma:

The American Association on Health and Disability and the Lakeshore Foundation submit comments on the skilled nursing facility prospective payment draft rules. We endorse the

comments submitted by the Coalition to Preserve Rehabilitation and many of the comments submitted by the National Consumer Voice for Quality Long Term Care.

The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

GRIEVANCE PROCESS

National Consumer Voice for Quality Long Term Care

Retention of grievance records for less than three years

We disagree that maintaining evidence related to grievances for 3 years is burdensome, unnecessary, and costly. Any documents concerning grievances will almost certainly be electronic. If not, handwritten documents can be scanned and become electronic. CMS itself notes in the preamble that "such evidence may be maintained electronically, rather than utilizing physical storage space." 68724 Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations). Preserving records online requires little to no effort or cost. Maintaining records can help facilities, not burden them. As CMS pointed out in the preamble, the evidence provides a record of grievance investigations and can serve as a valuable information resource for facilities. The documentation can indicate the types of problems they have had in the past, what was done to address them and if those efforts were successful. This can help LTC facilities avoid similar grievances in the future or consider different problem resolution strategies if previous ones were not successful. Grievance records can also assist facilities in proving that they did indeed respond to a resident concern in cases where that is called into question.

Removing requirements regarding specific duties of the grievance official

National Consumer Voice for Quality Long Term Care

We oppose giving facilities greater flexibility in how they ensure grievances are fully addressed.

- The duties specified in the regulation are basic and reasonable components of complaint investigation and resolution processes that anyone wanting to properly address a complaint would be following anyway,
- Facilities that do a good job of handling grievances are already carrying out these responsibilities; specifying these duties would help other facilities know what to do,
- Duties that aren't specified are usually not done,
- The duties are very broad, leaving a great deal of flexibility to facilities,
- Better requirements ensure that there is consistency in how complaints are handled.

Eliminating a grievance official to oversee the process

National Consumer Voice for Quality Long Term Care

- As CMS states in the preamble, a grievance official is necessary to ensure that there is an individual who has both the responsibility and authority for ensuring, through direct action or coordination with others, that grievances are appropriately managed and resolved.
- Facilities have been required for years to respond to complaints, so most (if not all), likely already have a person or persons who serve this function, if not with the specific title,
- The regulations do NOT require that this be a new, full-time hire. CMS writes, "It is not our expectation that every facility hire a new, full-time individual to perform this function, but, instead, that every facility have a designated individual to serve this function, consistent with the needs of that facility."
- If no one person serves as grievance official the responsibilities of handling concerns may fall through the cracks and complaints may be mishandled or not handled at all,
- Decreases accountability.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT (QAPI)

National Consumer Voice for Quality Long Term Care

Eliminating specific requirements regarding 1) how the program must be designed and 2) how a facility will determine underlying problems impacting systems in the facility, develop corrective actions, and monitor the effectiveness of its performance.

- QAPI is new in the nursing home setting and most facilities don't have a great deal of experience in creating and implementing a QAPI system. Requiring specific elements helps facilities know how to proceed and better ensures that all nursing homes develop and operate a QAPI process that is effective and useful.
- Requiring these elements promotes consistency between facilities so that all residents can benefit from an adequate QAPI process regardless of in which facility they reside.
- Not specifically requiring these elements means that important components are likely not to be included in the design or feedback, monitoring or analysis processes. Examples: 1) quality of life and resident choice could be left out of program design; 2) adverse event monitoring could fail to include the specific methods by which the facility will identify, report, track, investigate, analyze and use data related to adverse events. This could impact resident quality of life and care.

MEANINGFUL QUALITY MEASURES NEEDED

Coalition to Preserve Rehabilitation

CMS proposes to adopt four new outcome-based functional measures that address functional status for FY 2020, and invites comments on these measures. These measures align with the IRF Quality Reporting Program for FY 2020:

- Application of IRF Functional Outcome Measure: Change in Self-Care Score for Medical Rehabilitation Patients (NQF #2633);
- Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehabilitation Patients (NQF #2634);

- Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehabilitation Patients (NQF #2635); and
- Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehabilitation Patients (NQF #2636).

These are important new measures that we support in the SNF setting and in other settings of post-acute care. Many of the measures being implemented in the PAC setting are process measures, and those that are more akin to outcome measures are fairly rudimentary. CPR favors quality measures in PAC environments that accurately assess beneficiaries' functional status and address the real-life needs of beneficiaries, including beneficiary experience, engagement, and shared decision-making measures. The four measures proposed herein move SNF quality measurement in this direction. Measuring the change in patient's self-care and mobility status between SNF admission and discharge is an important functional measure that can be readily compared across PAC settings.

As PAC quality measurement continues to mature with implementation of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act, we urge CMS to ensure that community-based functional measures are implemented so that beneficiaries with disabilities and chronic conditions will be better informed of their key concerns following illness or injury. These concerns certainly include the ability to achieve sufficient functional status to be discharged from a SNF and return to the home and community-based setting. They also include the ability to live as independently as possible; to function at the maximum extent possible; to perform activities of daily living; to return to employment if desired and appropriate; to engage in recreational and leisure activities; to exercise with or without assistive aids; to engage in community, civic and social activities; and to maintain the highest quality of life possible.

DISCHARGE NOTICES
National Consumer Voice for Quality Long Term Care

CMS Question #1: Is sending the discharge notice to the long-term care ombudsman achieving intended objectives to reduce inappropriate involuntary discharges?

- Inappropriate involuntary discharges are an ongoing and serious problem that long-term care ombudsmen have been investigating and working to resolve for many years. In fact, involuntary discharges are the number one complaint that ombudsmen handle in nursing homes. Long-term care ombudsmen advocated for this mandatory notice in order to assure that residents have the fastest and easiest possible access to their services when facing possible eviction.

- Requiring facilities to notify the Ombudsman Program of involuntary discharges affirms CMS's stated commitment to person-centered care by improving residents' access to the services of the Ombudsman Program to assist during the discharge process. It also achieves CMS's stated goal of protecting residents and ensuring the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges (Survey and Certification memo; May 12, 2017; S&C: 17-27-NH).

- Past experience in states where notice was already required to go to ombudsmen shows that receiving notices reduces inappropriate discharges. Ombudsmen are able to contact the resident and/or representative and provide assistance if requested. The majority of the time ombudsmen are successful in resolving a problem or concern that has triggered the proposed discharge, thereby allowing the resident to remain in his or her home.

- Reducing inappropriate discharges benefits residents.
    - Residents are able to stay in their homes, avoiding the trauma of being relocated which can result in: falls, weight loss, self-care deficits, anxiety, increased confusion, apprehension, depression, loneliness, vigilance, weight change, insecurity, withdrawal, sadness, restlessness, sleep disturbance, crying, feelings of hopelessness and helplessness.
    - Residents receive consistent care, which improves health outcomes.

- Reducing inappropriate discharges benefits facilities.
    - Facilities gain a stable resident census since ombudsman participation often resolves the underlying root cause of the issue so discharge is not necessary. That, in turn, allows facilities to concentrate on residents they know and makes it possible for facilities to provide consistent care.
    - Facilities experience decreased burden since frequent discharges result in substantial turnover in residents which means staff must handle the paperwork required by more admissions, more assessments, more care plans, and more consults among the departments as facilities are required to provide person-centered care to each new resident along with the current residents.

- Reducing inappropriate discharges reduces costs.
    - When ombudsmen address the underlying cause of the problem, the state does not incur the cost of an appeal hearing or an investigation.
    - Avoiding the effects of transfer trauma which can lead to a need for increased care and treatment can save money for both Medicare and Medicaid.
    - Preventing a discharge when a resident has been sent to the hospital can save Medicare thousands of dollars in cases where the hospital cannot place the resident and the resident remains in the hospital awaiting admission.

- Since the regulations have only been in effect for less than 7 months, it is likely that inappropriate discharges will be further reduced as ombudsman programs nationwide fine-tune and fully implement their systems for receiving and responding to these notices.

- To fully achieve the intended objective, nursing homes must comply with this requirement. State survey agencies must cite facilities for failing to send the discharge notice to residents and then take effective enforcement action.

CONTINUED EXCLUSION OF CUSTOMIZED PROSTHETIC DEVICES FROM THE SNF PPS

Coalition to Preserve Rehabilitation

In the proposed rule, CMS invited comment identifying Healthcare Common Procedure Coding System ("HCPCS") codes under the prosthetic limb benefit that represent recent medical advances and might meet its criteria for exclusion from SNF consolidated billing. CMS stated that it may consider further exclusions of prosthetic devices/services if they meet its criteria for exclusion. CMS further stated that commenters should identify in their comments the specific HCPCS code that is associated with the device/service in question, as well as the rationale for requesting that the identified HCPCS code(s) be excluded.

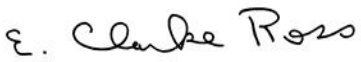
Exclusion of prosthetic limb codes from the SNF PPS/consolidated billing rules has been shown to dramatically improve access to reasonable and necessary prosthetic limb care during patient stays at skilled nursing facilities. As discussed in the proposed rule, §1888(e)(2)(A) of the Social Security Act (SSA) excludes certain high cost, low probability services from the SNF PPS payment system. The reason for this exclusion is historical. The Balanced Budget Act of 1997 transitioned SNFs to consolidated billing and a per diem payment system, and prosthetic and orthotic care was originally included in this system.

Shortly thereafter, Medicare data revealed that patients were no longer gaining sufficient access to prosthetic devices/services during the SNF stay, presumably because prosthetic care is individualized and relatively expensive in relation to SNF per diem payment rates. The theory behind exempting prosthetic codes from the SNF payment system was that SNFs could arrange for the provision of required prosthetic care for their patients during the SNF stay and the prosthetic provider or supplier could bill this care separately under Medicare Part B.

This has been permitted since passage of the Balanced Budget Refinement Act of 1999, which listed a significant number of exempted prosthetic HCPCS codes from the SNF payment system and gave CMS authority to update this list in the future. CPR strongly supports the continued exclusion of customized prosthetic devices and related services from the SNF PPS system as their exclusion helps ensure timely and appropriate care to patients with limb loss in the SNF setting. Unfortunately, the 1999 law did not include a similar set of exempted HCPCS codes for custom orthotics.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,



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