



National Association for the Support of Long Term Care

August 25, 2017

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

Re: CMS-1686-ANPRM; RIN 0938-AT17: Advanced Notice of Rule Making: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to Case-mix Methodology

Dear Administrator Verma:

The National Association for the Support of Long Term Care (NASL) is a trade association representing suppliers of ancillary services and providers to the long term and post-acute care (LTPAC) sector. NASL members include rehabilitation therapy companies that employ more than 300,000 physical therapists, occupational therapists and speech-language pathologists who furnish rehabilitation therapy to hundreds of thousands of Medicare beneficiaries in nursing facilities, as well as to beneficiaries in other long term and post-acute care settings. NASL members also include both vendors of health information technology (IT) that develop and distribute full clinical electronic medical records (EMRs), billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers of assisted living, skilled nursing and ancillary care and services. Additional services and products provided by NASL members include clinical laboratory services, portable x-ray/EKG and ultrasound, complex medical equipment and other specialized supplies for the LTPAC sector. NASL is a founding member of the Long Term and Post-Acute Care Health Information Technology Collaborative (LTPAC Health IT Collaborative), which was formed in 2005 to advance health IT issues by encouraging coordination among provider organizations, policymakers, vendors, payers and other stakeholders.

NASL is pleased to submit these comments following the release of the Advanced Notice of Proposed Rule-Making that would revise the SNF payment mechanism from RUG IV to the Resident Classification System-1 (RCS-1). NASL's first concern is the patient. Since NASL's review of earlier versions of the RCS-1, we have been concerned regarding the lack of discussion of beneficiary protections. Further, we are concerned that the payment model under consideration by CMS is not simple nor is it a refinement of the current Prospective Payment System (PPS). The model under consideration is a complex new payment model that does not align, coordinate or take into account the impact of current payment mandates such as the

IMPACT Act and the SNF Value Based Purchasing program. NASL is concerned that the new model as it currently stands could create disruption and confusion for providers and patients. Implementation could occur just as SNF providers are preparing for a Unified Payment System for Post-Acute Care as required by the IMPACT Act. While NASL members support moving away from the highly criticized incentives embedded in the current payment system, we are doubtful that the Resident Classification System—as it stands today—is the right next step because of the flaws in the model. Because of our concerns, NASL recommends that CMS submit the model under consideration to peer review so that the research can be further reviewed in terms of the data sources and methods used to build the model. Further, NASL recommends that CMS undertake a stakeholder discussion process separate from Open Door Forums and the formal rulemaking process to vet the model with stakeholders, and facilitate discussion on the impacts of the model.

In our review of the RCS-1 model under CMS consideration, we see that it is a payment model built on historical costs of nursing and therapy and other patient need. In application, the payment model pays based on a diagnosis with some modifiers for function, etc. The PT-OT and SLP therapy component reimbursements are based on a predetermined amount that the payment category computes for a patient in a particular diagnosis category with some modifiers. That payment has no correlation to the actual therapy provided to the patient. More specifically, the model does not take into consideration or base the therapy reimbursement on the results of the patient's evaluation, or the plan of care which would indicate the intensity and duration of the therapy needed. This leads us to believe that the patient could be scored for a therapy payment but the provider may not have to provide that therapy. This could apply to other aspects of the care like wound therapy, a non-therapy ancillary item. We conclude that the payment has little correlation with the actual care provided after the point at which the initial assessment is conducted and the payment category is established. We have grave concerns that this situation could be detrimental for the patient and set up compliance issues for the provider.

1. Ensuring Appropriate Care, Access and Protecting Beneficiaries

CMS has conducted extensive research into an alternative to the current SNF Prospective Payment System (RUG-IV), believing that the existing payment mechanism does not accurately reimburse SNFs in accordance with the cost of care delivery. RCS-1 would create five components that together make up the per diem. Physical and occupational therapy are split apart from speech language pathology and there is a component dedicated to paying for non-therapy ancillaries to offset the cost of expensive medications and treatments. The model would base per diem rates on a variety of factors, such as the diagnosis, physical condition, cognitive status and clinical complexity of the patient. Per diem rates would not be consistent throughout the stay, but would be front-loaded to a certain extent to offset the higher costs incurred during the early part of a SNF stay. Per diem rates would no longer be affected by the number of minutes of therapy provided.

NASL believes that, in redesigning the SNF PPS, it is critically important that the new system supports and encourages patient-centered care, access to care and encourages the delivery of high quality care. We are particularly concerned that the model under consideration be structured to both protect the patient and encourage the delivery of excellent care. Under RCS-1, providers will be paid a pre-determined rate for physical and occupational therapy that will be automatically adjusted downward in the same way for all patients without consideration of actual resource utilization and equitable reimbursement for the resources used. While NASL supports moving away from the current system that has a perverse incentive to over-utilize therapy, NASL is concerned that CMS has swung the pendulum too far by de-emphasizing the provision of rehabilitation therapy. The PT/OT component and the SLP component are two of the factors that determine reimbursement, regardless of whether these services are actually provided, which may lead providers to be reluctant to incur the cost of providing care and services needed by patients to achieve the greatest degree of independence and best quality of life possible over the duration of the stay. Stinting on the provision of therapy services is not only dangerous to patients, it may actually lead to increased costs to the system because of rehospitalizations and poor clinical outcomes. NASL wishes to understand the steps CMS will take to ensure the safety of patients in this model, protect beneficiaries from stinting and ensure the provision of an optimal amount of therapy services. In order to protect patients, NASL also requests that CMS require reporting on specific quality indicators and clinical outcomes that could align with therapy services, such as falls and the improvement and maintenance of functional status. The IMPACT Act requires similar measures but the RCS-1 model does not align with the IMPACT Act as discussed elsewhere in our comments.

2. Coordination and Alignment with Other Initiatives

SNFs are subject to reporting requirements under the IMPACT Act of 2014, the new SNF Value-Based Purchasing Program, BPCI bundling initiatives, the new Medicare Requirements for Participation and MACRA related changes. When questioned about how RCS-1 would align with these other requirements, Acumen stated in technical expert panel meetings that coordinating requirements with other laws and initiatives is outside their scope of work. Quality measures, resource use measures and other data reporting requirements all have financial penalties for non-compliance. These requirements cannot be ignored when building a new payment system. Additionally, CMS is developing a Unified Post-Acute Care payment model (PAC PPS) as required by the IMPACT Act which will eventually be overlaid onto the Part A payment system.

The RCS-1 does not acknowledge other requirements mandated for providers including the law and programs listed above. NASL believes a new payment system must be aligned with other current requirements given the complex reimbursement environment in Medicare. SNF Part A reimbursement is not a siloed fee-for service program anymore. SNF Part A services are now value based as required by the IMPACT Act, SNF Value-based Purchasing, requirements of 5-Star, SNF participation in ACO's, BPCI and other bundling, episodic and

risk based programs. Part B services are now value driven as well under MACRA. Other than MedPAC stating that the future Unified Post-Acute Care prospective payment system (UPAC PPS) could be layered onto RCS-1, we see no elements of the RCS-1 that align or coordinate with these current programs. NASL requests a roadmap or timeline for how RCS-1 will align with the implementation of all the programs listed above as well as UPAC PPS. We further request information about how the quality reporting financial incentives and penalties for non-compliance with reporting requirements have been taken into account in designing RCS-1. If the model was created before the requirements existed, NASL seeks to gain an understanding of how the model will be updated to take them into account.

3. Payment Rates Set Upon Admission with an Unclear Adjustment Mechanism

Patients will be assigned to clinical categories through assessments to be conducted upon admission to the SNF. Unlike RUG-IV, which requires assessments and potential payment adjustments at days 5, 14, 30, 60 and 90 of a stay, RCS-1 only requires an admission and discharge assessment unless there is a significant change in the condition of the patient.

NASL is concerned that the current guidance provided by CMS in the RAI Manual is not sufficient in clarifying what constitutes a significant change in condition for it to be used in RCS-1 and believes it is very possible that SNFs may not receive adequate payment for services required by patients. NASL is seeking additional clarity on exactly what constitutes a significant change in condition that will trigger an assessment.

NASL is concerned that the use of the MDS Significant Change appears inconsistent with historic lessons learned through the evolution of PPS. Absent the ability to accurately identify patient needs and the utilization of services, several changes in MDS assessments have been necessary. To assure patient-centered care and the necessary accommodations to service patterns for the medically complex SNF patient, the COT, SOT and EOT OMRA have been added to the five established MDS assessments for PPS RUG-IV. These additions have been necessary to assure accurate reporting of rehabilitation services and/or the medical diagnoses attributable to the subtle medical changes in the patient during a Part A stay.

NASL does not believe the proposed system addresses payment for expensive medications that may be added to a patient's regimen after admission, but would not change the case mix. We are also concerned about the situation where expensive medications are added to a patient's regimen after admission and the facility begins receiving a decreased NTA after day 3, yet the expensive medications are still being administered due to the patient's condition. NASL also believes a change in condition should re-start the payment clock to day one. NASL is concerned that certain components of RCS-1 do not take the complexity of the patient's condition into account. For example, while the speech language pathology and non-therapy ancillary components are adjusted based on the presence of comorbid conditions, the PT and OT components are not.

NASL requests a mechanism be made available that is consistent with the types of changes known to be typical of the SNF patient population and do not currently warrant a Significant Change MDS under the current definition according to the RAI manual. The mechanism would be one that allows proper identification of the clinical condition of the patient, acknowledges changes in patient diagnoses through the duration of the SNF stay and that allows for equitable compensation for the actual services provided.

4. Dramatic Reduction in Payment Rates for Patients with HIV/AIDS

Under RUG-IV, payment rates for patients who have HIV/AIDS are adjusted by 120%. CMS would eliminate this adjustment under RCS-1 and instead increase the case mix weight for the nursing component by 19% and assign the highest point value for the non-therapy ancillary component. As a result, under RCS-1 CMS estimates that per diem rates for HIV/AIDS patients would be reduced by 40%.

NASL is profoundly concerned that such a drastic reduction in rates will result in providers being unwilling to provide care and services to this very vulnerable population. NASL requests that CMS continue to adjust rates by 120% for HIV/AIDS patients under RCS-1. NASL also requests that the adjustment be applied to patients who have HIV/AIDS but are in the SNF for a different primary diagnosis. NASL does not believe the proposed adjustment would cover the cost of the very expensive drugs needed to treat patients with HIV/AIDS. According to the NIH (aidsinfo.nih.gov/guidelines) the use of three or more antiretroviral drugs is currently the standard treatment for HIV infection. According to NIH, the average wholesale price of each of these medications ranges from \$283 to more than \$4,000 per month. NASL is concerned that the severe cut in payments will result in payments not covering the cost of the care and medications needed to support patients with HIV/AIDS; as well as the potential for facilities to avoid caring for these patients due to this disparity.

5. The RCS-1 Model's Impact on Health IT Development, Innovation & Interoperability

Health information technology (health IT) serves a critical role in helping providers to improve care delivery, coordination and quality while delivering efficiencies needed to fully participate in value-based care. As standards and technologies continue to evolve, and as technology becomes more integral to federal health policy, we ask that CMS and other federal agencies take into account how federal policymaking affects both innovation and business operations. NASL greatly appreciates CMS' growing recognition of the health IT development timeline and appreciates CMS' comments on collaboration with vendors in the *Advanced Notice*.

Payment system modernization is dependent upon more sophisticated health IT, not only for payment, but for outcome measurement as well. Long term and post-acute care (LTPAC) providers were not included in the *Health Information Technology for Economic & Clinical (HITECH) Act* meaningful use funding opportunities. The LTPAC sector has struggled to keep

pace with CMS and market-driven payment and quality outcome measurement initiatives that depend upon sophisticated health IT. In fact, CMS notes this issue in its Episode Payment Models (EPMs) proposed regulation. Specifically, CMS points to research, which notes, “a recent national survey of IT in nursing homes showed common use for administrative activities but less use for clinical care.” The RCS-1 model is of such a high-level of complexity that providers without information technology systems to help them may find the payment model to be a substantial challenge.

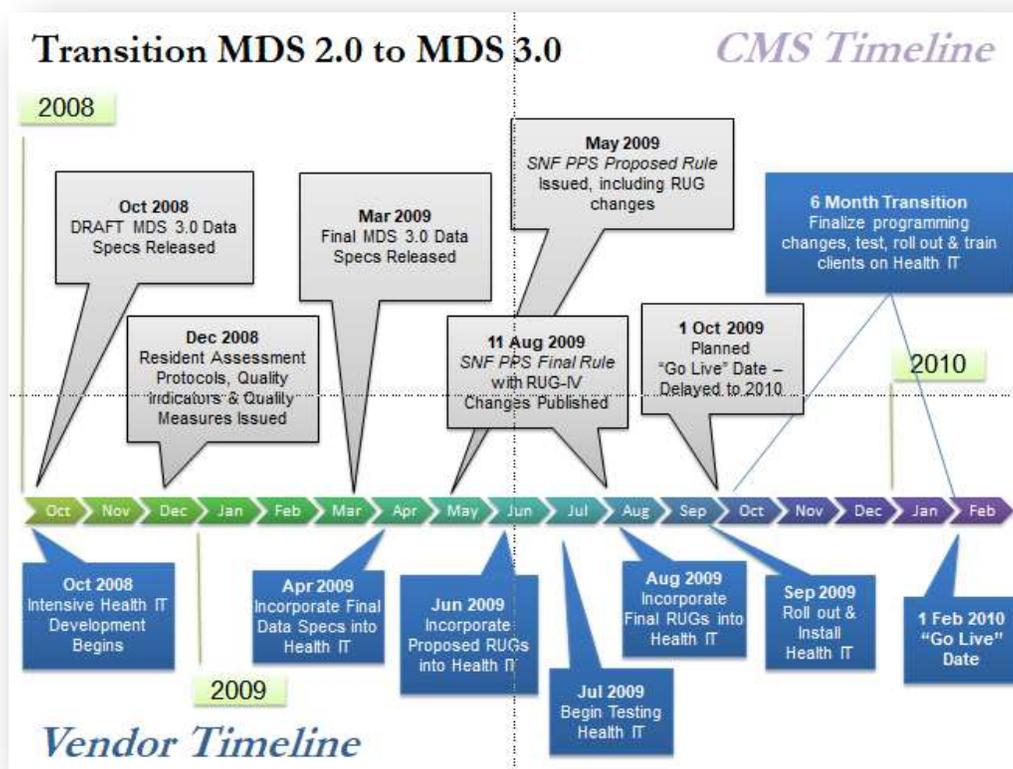
Information technology developers and their nursing facility clients are facing concurrent demands to program and deploy software that reflects the aggressive schedule imposed by the *IMPACT Act*, the phased-in revisions to Medicare’s *Requirements of Participation*, the annual changes to systems as required by the PPS payment system, the move to ICD-10, and other IT changes that position nursing facilities to respond to the new value-based environment – all of which demand a great number of modifications to health IT systems.

The RCS-1 model is extremely complex. We have seen estimates that RCS-1 will create upwards of 100,000 payment categories given all five payment components and their adjustors. IT developers face the task of programing this new model for nursing facility clients in the short span of time between the release of a final rule and the effective date of the new model, which could be several months. NASL members follow the development of the model very closely in order to prepare, but it cannot be overemphasized that developers can only program final specifications, not draft specifications, and we know that any policy in a proposed rule could be altered or not be included in a final rule. Should CMS bring any such wholesale change forward, NASL recommends that these changes be phased-in, and CMS should provide IT developers and providers sufficient time to implement complex changes and allow health IT developers to adequately prepare and institute technical changes, test and verify changes and adapt to the inevitable technical hiccups, glitches and full-scale problems that are inherent to such transitions.

6. Information Technology Development Cycle

As CMS implements more and more policy that providers must incorporate into their electronic health records (EHRs) and other software analytics and operations, CMS and other federal agencies must be cognizant of health IT development cycles and must be aware that changing health IT programs and systems takes time. Incorporating newly adopted standards or revised specifications into the development cycle takes time – time to incorporate, test and verify that the new standard or specification is operating as expected. It also takes time to roll out updates and new products to clients, who will need time to train staff and implement policy changes.

In 2008, CMS proposed massive reforms in transitioning from MDS 2.0 to MDS 3.0, and from RUG-III to RUG-IV. NASL members – and many veteran CMS staff – recall the challenges surrounding that transition and the many delays that were needed to troubleshoot and manage the substantial changes to both health IT systems and paper-based systems used by SNF providers. Because some states opted to maintain MDS 2.0 for Medicaid reimbursement, some providers had to plan to maintain MDS 2.0 and be able to complete both versions of the MDS. To give a sense of timing, the graphic below reflects both CMS' and vendors' timeline in transitioning from MDS 2.0 to MDS 3.0 and illustrates the multiple steps involved with such a transition.



Unlike in 2008, CMS is obliged to meet another aggressive timeline around implementation of the *IMPACT Act*. This multi-year schedule calls for considerable changes to the MDS as evidenced by last year's addition of Section GG and the continuing roll out of quality measures over the next few years. The investment of time and resources devoted to standardizing data across post-acute care settings cannot be understated. We believe the change to RCS-1, should CMS move to implement this system, will require more development lead time than the change from MDS 2.0 to MDS 3.0.

The RCS-1 model will not be programmed in a vacuum as IT developers and their nursing

facility clients already are managing a series of programming changes – all at the same time. Providers are still making the transition to ICD-10 coding, which began in 2014; there are additional tracking and increased pressures on health IT development timelines from various payment models being piloted by CMS; and more than 60 changes are needed to the existing MDS 3.0 based on the newly revised *Requirements of Participation (RoPs)* that long term care facilities must meet in order to participate in the Medicare program.

Estimating how much time IT developers need is difficult in the abstract. We offer the following example of a typical “paper” process to illustrate the amount of time required to design, produce and deploy relatively minor changes to an existing patient assessment instrument. Clearly, the time to program and deploy a complex payment system such as RCS-1 is substantially more than what is needed for this paper example below.

Example – Regulatory Form Design & Manufacturing Process Timeline

- **Document Design** – Depends on CMS final specifications & *Interpretive Guidelines*. Final approval needed 90 days before regulatory change takes effect.
- **Clinical Review** – Clinicians create/amend document. Incorporating all clinical input/changes can take several weeks.
- **Composition & Graphic Design** – Depending on page count & number of changes, design can take 2-3 weeks.
- **Print/Manufacture Paper Documents** – Allow 2-4 weeks to schedule & complete print cycle. Digital Development – allow ~ 8 hours per page; MDS has 40+ pages. EMR partners receive 60 days prior to effective date. Products are shipped to customers 3 weeks prior to an effective date.

7. More than Time Is Needed

The economic impact that this *Advanced Notice* would have on LTPAC providers and health IT vendors alike cannot be understated. *NASL recommends that CMS consider cost estimates included in the Office of the National Coordinator for Health Information Technology’s (ONC’s) 2015 Edition Final Rule to gain an appreciation for the kind of time and resources that such wholesale changes would require.* We believe that if the *Advanced Notice* were to move forward, the changes would require thousands of development hours by each IT company to change existing systems, while maintaining existing products that may still be needed to support state-based requirements. Likewise, providers would need to devote time and resources to deploying new systems and training staff. Plans to implement innovations would be scuttled or

held in abeyance as development timelines and available manpower would shift to accommodate programming for the new model. Such massive changes would cost multiple thousands of dollars for a sector that is already operating on narrow margins. ***NASL recommends that CMS factor information technology modernization of health care delivery into the impact analysis of this payment model. Additionally, NASL recommends that the cost of health information technology must be included in any non-case mix component redesign.***

NASL strongly believes that health IT holds much promise for improving patient care and delivering savings for Medicare, Medicaid and our nation's healthcare system. These opportunities may be missed if the resources we are expending now to connect with hospitals and patients, to achieve interoperability, and, most importantly, to improve care coordination and care quality are sidelined to work on fundamental changes to the reimbursement system for the LTPAC sector.

8. Budget Neutrality

CMS is seeking comments as to whether the transition to RCS-1 should be budget neutral.

NASL believes the transition should be overall budget-neutral and does not believe that CMS has the authority to make such a change in a way that is not budget-neutral.

9. Calculation of Functional Scores

CMS intends to limit the use of ADL scores to three items in order to calculate the functional score and not use any information on supportive measures. RCS-1 would use Section G of the MDS to record both ADLs as well as the functional scores; causing continued confusion about the various uses of Section G vs. Section GG.

NASL is concerned about eliminating supportive ADL services from the scoring methodology for the functional score as that component can be indicative of the burden of care and should be included in the calculation. NASL is also concerned about using Section G to score ADLs and functional score potentially adding to provider confusion about Section GG.

10. The Provision of Therapy Services – Restrictions and Reporting Requirements

NASL understands CMS' desire to move away from a payment model that sets reimbursement rates in part based on the volume of therapy provided. However, in the ANPRM, CMS comments several times on collecting information on the minutes of therapy provided. CMS also would limit group and concurrent therapy to a maximum of 25% each of the total amount of therapy provided.

NASL is concerned that CMS may require data collection on the volume of therapy minutes provided, despite the fact that the transition to RCS-1 is predicated on a desire to move away from relying on the volume of care provided as a driver of rates. NASL believes the UB-O4 will continue to show the utilization of rehabilitation services by nature of the current claims processing process, making additional reporting unnecessary and duplicative. NASL further believes requiring providers to report on the volume of therapy services provided by the minute will create an undue burden on providers.

We are concerned that the limits on group and concurrent therapy are arbitrary and not supported by clinical data. In the ANPRM, CMS discusses the need for value-based care and lifting constraints on providers so that they can provide care efficiently to obtain the best and desired outcomes. NASL believes that CMS dictating a limit on the type or volume of therapy to be provided interferes with the professional judgment of providers and conflicts with patient-centered care. NASL believes CMS would cross the line into clinical decision making by dictating the potential volume of group and concurrent therapy.

NASL requests clarification as to when the adjustment factor would be applied to therapy cases. If therapy does not start on day 1 of the admission, will the 14th day occur on the 14th day of the admission or 14 days after therapy has begun?

Additionally, NASL believes that the therapy components should have a larger wage index adjustment because therapy is almost exclusively a labor related cost.

11. Concerns with the Data Used as a Basis for RCS-1

CMS used assumptions from 1995 data that was used to establish a 1998 payment system, STRIVE results from 2006 and one year of claims data from FY2014 to design RCS-1. It should be noted that RCS-1 was designed based on information and practices prior to the implementation of ICD-10.

In many other previous sets of comments, NASL has expressed its concern about CMS depending upon STRIVE data. NASL believes that, not only is the study outdated, but the methodology was flawed. Key flaws include a number of facilities that did not have sufficient electronic devices to track data and thus used a different methodology than the rest of the sample facilities. Also, the methodology used to classify direct time varied among providers. Information was collected on paper and the collection was so erratic that CMS used the 3rd day of a 7-day period and then extrapolated the data for 7 days.

Using FY 2014 data means that CMS did not use data from claims filed after the implementation of ICD-10. NASL believes CMS should update the design of RCS-1 to account for the implementation of ICD-10, especially given the significant reliance on diagnosis coding in the RCS-1 model. NASL also believes CMS should use more current data, such as FY 2016 and not just a one-year snap shot in time.

NASL understands the first line in section I8000 would be used to report the ICD-10 CM code. This would record the diagnosis that is the “primary reason” the patient is in a SNF. However, as Section I8000 has historically been utilized to identify “additional” active diagnoses, and not the primary diagnosis or the reason for the SNF stay or the provision of therapy, significant education, provider training, and revision to the RAI Manual would be required. Furthermore, most SNF patients have multiple comorbidities. NASL believes the grouper should search all codes in Section I in order to obtain a comprehensive picture of the patient.

Limiting the selection of the clinical category to information entered solely in I8000A creates an undue burden for providers, leading to potential coding and provision of care issues. For example, a patient is admitted to the hospital for a hip replacement secondary to arthritis and during the surgery suffers a stroke. The stroke or CVA is captured on the MDS by item I4500 and the hip replacement is identified in I8000A. In this scenario, the patient would be clinically classified for PT/OT as Major Joint Replacement and for SLP as Non-neurologic, despite the potential issues with swallowing and/or cognition based on the stroke. A true reflection of the patient’s overall condition and needs is not captured. Without a mechanism to account for all active diagnoses, the coding and the clinical category may not accurately reflect the patient’s condition and therefore impact the provision of care.

In addition, reliance on a single diagnosis to categorize a patient for PT/OT and SLP could create scenarios of seeming upcoding or downcoding. If a diagnosis such as R26.9, unspecified abnormalities of gait and mobility, is entered in I8000A, the patient would be placed in the Acute Neurological clinical category for PT/OT and SLP, yet the patient may not have a deficit to be addressed by SLP. Other unintended consequences could also arise, perhaps during the auditing process, if a diagnosis is not listed to support the clinical category identified. Based on the example of R26.9, the lack of a supporting neurological medical diagnosis, such as MS or Parkinson’s, to support the Acute Neurological clinical category, could lead to the supposition of upcoding. As already stated, significant education and guidance would be required to ensure accuracy and avoid unintended coding errors.

Despite repeated requests, we have not been provided with the grouper. NASL once again requests access to the grouper so that NASL members, including providers and Information Technology companies, can more adequately understand the model under consideration.

ICD-10 includes more than 70,000 codes. SNFs typically do not have trained coders in every facility. NASL is concerned that SNFs could be accused of “upcoding” when actually there could be a lack of understanding of how to code appropriately. NASL believes CMS should establish codes similar to acute care hospital DRGs, that have codes with complications and without complications. NASL also believes that CMS could move toward a system more like the IPPS, where DRGs or payment categories are assigned at the conclusion of a stay, taking into account all activity that occurred during the stay. The DRG system appears to be more accommodating of accounting for changes in patient condition during a stay.

NASL is concerned that CMS' research contactor excluded a significant percentage—almost a third—of cases from the 2014 population of Medicare coverage stays that the research for the model is based upon. Page 17 of the SNF Payment Models Research Technical Report states, "As shown in Table 6 the final study population contains 73% of total stays." This tells us that the researchers excluded 27% -- almost a third of total stays for their research. We request that CMS investigate this finding more closely to determine if the patient stays that were excluded are pertinent to the research and pertinent to reasons as to why the payment system is being changed. This supports our assertion that the research should be subjected to peer review and further stakeholder discussion.

12. Process Concerns

In the ANPRM, CMS does not address what will happen if the model proves to be highly inaccurate. CMS does not make a provision to change the model if it notes a significant overpayment or underpayment to providers. The model does not appear to have been tested using complete clinical documentation rather than strictly claims data. Under RUG-IV, if a patient is in a SNF to receive therapy, coding multiple comorbidities would not increase reimbursement unless they impact the functional status of the patient. It is possible that the 2014 claims data could be lacking information that under RCS-1 will impact reimbursement. Additionally, NASL and other provider groups have requested the grouper so that they can accurately assess the impact RCS-1 will have. CMS has not released the grouper.

NASL believes the model is not ready to be tested and instead should be submitted for peer review by others. NASL also believes CMS should establish a mechanism to adjust the model if it is inaccurate. NASL requests access to the grouper.

13. Impact on Other Payers

Many Medicaid programs and Medicare Advantage programs base their payment rates on the Medicare Part A Fee for Service case mix system.

NASL requests information on how CMS anticipates implementation of RCS-1 will affect Medicaid and other payment mechanisms.

14. Non-Therapy Ancillary Component

In RCS-1, CMS creates a non-therapy ancillary component (NTA) that is designed to offset the cost of expensive medications and equipment. CMS uses 27 elements to establish the NTA score.

NASL requests information on the rationale behind the point system for the NTA. We are concerned that certain conditions have been undervalued. For example, why is a Stage IV wound only awarded one point? We are concerned that awarding five points for an IV medication could lead to increased utilization of IV medications that could be eliminated in

favor of oral medications, potentially leading to unnecessary clinical complications such as infections and phlebitis. We are concerned that there are multiple categories of transplants within the point system, and request an explanation as to the logic behind the system.

Additionally, the NTAS component of the RCS-1 should not be wage index adjusted because most of the items contained within the NTAS component do not include significant labor components that occur at the SNF (e.g. prescription drugs, DME, lab, radiology, medical supplies, etc.).

Conditions such as Congestive Heart Failure (CHF), which has repeatedly been proven as a diagnosis and/or comorbidity associated with an increased risk for re-hospitalization, is not a condition listed in the NTA. Given the demonstrable push to decrease re-hospitalizations, leading to improvements in patient care through evaluation, treatment, and continual assessment of patients with these types of diagnoses, it appears to be a substantial gap in the RCS-1 system. This gap again indicates a need to potentially adjust the NTA and its counterparts to account for patients' complexities and comorbidities but also leads back to concerns regarding the outdated clinical, financial, and coding data utilized to create this system and without consideration of changing requirements, such as SNF VBP.

In addition, areas of growing importance as evidenced by changes to the Requirements of Participation and proposed changes to the MDS, do not appear to be adequately addressed. Items such as dementia management, opioid use, and antipsychotic/antianxiety medication use do not appear to be accounted for in this model, despite the potential need for additional education, evaluation, assessment, and treatment.

15. Outliers

CMS has stated it does not believe it has the statutory authority to create an outlier pool to offset the cost of caring for very resource-intensive patients.

NASL believes that any change to the existing payment mechanism should include an outlier payment. Failure to include an outlier payment in the new system could lead to providers declining complex cases that are resource-intensive.

16. Assessing Cognition

CMS has stated it will use the Cognitive Function Scale, a combination of the BIMS and the CPS, to evaluate cognitive function.

Cognition is a broad area and not easily assessed comprehensively. The scope of practice for OTs, PTs and SLPs includes the assessment of cognition and the ability to identify changes in cognitions. The BIMS and the CPS are basic screens and may not paint a comprehensive picture of cognitive impairment. NASL questions whether the CFS has been proven to

adequately address all areas of cognition and can provide an accurate assessment of the patient's cognitive status?

We caution that the cognitive assessment may not be fully accurate at the time the admission assessment is conducted, particularly if the patient is weak or disoriented after hospital discharge. The extent of cognitive impairment may become more evident once therapy begins, the patient becomes more active, and as care addresses the immediate frailties and risks early in the stay. This underscores the risk in having one assessment determine payment for the entire stay.

We question whether the CFS will be adequate to determine executive function and dementia and the extensive care needs that it requires. CMS has stated as recently in the Proposed Rule on Long Term Care Facilities Requirements for Participation that the nursing home patient population is increasing with respect to dementia and behavioral health issues. The Proposed Rule states, "Nursing homes are also caring for a significant number of residents who require behavioral health services. In 2004, over 16 percent of nursing home residents received a primary diagnosis of a mental disorder upon admission (Jones, Figure 7). By the time residents were interviewed for the National Nursing Home Survey that percentage increased to almost 22 percent. The 1999 estimate was about 18 percent. In addition, nursing homes are caring for a significant number of patients with dementia and depression. By 2012, over 48 percent of nursing home residents had a diagnosis of Alzheimer's disease or another dementia and/or depression (Harris-Kojetin, p. 35, Figure 23). Similarly, in looking at the prevalence of four mental health conditions (depression, anxiety disorders, bipolar disorder, and schizophrenia) in nursing home residents 65 and older, the Institute of Medicine (IOM) found almost 50 percent had depression and almost 57 percent had one or more of those conditions (IOM 2012. The mental health and substance use workforce for older adults: In whose hands? Washington, DC: The National Academies Press). In addition, substance abuse disorders are also increasing in the nursing home population. To accommodate a more diverse population, the current care and service delivery practices of LTC facilities have changed to meet these changing service needs.

17. Compliance Concerns

CMS used claims data that predates the implementation of ICD-10 to develop RCS-1.

NASL is concerned that SNFs may experience difficulty in complying with ICD-10 coding requirements, leading to billing compliance issues. Under RUG-IV, diagnosis coding does not have a direct impact on reimbursement. The RCS-1 system adds complexity to the coding process. For example, section I8000A will be used to record all diagnoses, not just the primary diagnosis requiring an enhanced level of specificity. This will be a new approach to coding not used in SNFs before. NASL is concerned that CMS did not take the additional expense and burden of hiring and educating coding staff into account in creating RCS-1.

NASL is also concerned that providers may run afoul of compliance requirements related to coding because of a historic lack of resources devoted to accuracy in coding and the increased complexity of the system. NASL seeks information on how CMS will work to ensure that providers are not inappropriately targeted for compliance audits and enforcement actions based on coding accuracy.

18. Clinical Categories

In developing RCS-1, CMS used diagnosis and claims data that predates the implementation of ICD-10. CMS has not provided a crosswalk of diagnoses between ICD-9 and ICD-10 related to the implementation of RCS-1.

Additionally, respiratory therapy does not appear to have been included in therapy categories in RCS-1, but is considered rehabilitation under the new Requirements of Participation. Neither the nursing or therapy components of the payment rate appear to have been adjusted to account for the provision of respiratory therapy.

In trying to map diagnoses, we have found that each ICD-9 code could be classified as any of three or four ICD-10 codes. We request that CMS provide a cross-walk for codes to be used under RCS-1. We are concerned that the degree of specificity of ICD-10 coding has not been built into the model. We are concerned that the model uses one ICD-10 code to base all rehabilitation needs. There could be significant problems with this. For example, when looking at the PT/OT components there is a clinical category for Major Joint Replacement and Other Orthopedic. We are concerned that this will not be an accurate capture of clinical category for fractures repaired with joint replacement now that we have ICD-10 since the RCS-1 was based on ICD-9. There was a significant change in coding rules from ICD-9 to ICD-10 as it relates to fractures repaired with joint replacement. Under ICD-9, a fracture repaired with joint replacement was coded as a joint replacement. Under the current ICD-10, a fracture repaired with joint replacement is coded as a fracture. Patients that were in major joint replacement under ICD-9 will be under Other Orthopedic with ICD-10.

RCS-1 does not appear to classify respiratory therapy in a manner that is consistent with the new Requirements of Participation. Under the new Requirements of Participation, SNFs must offer respiratory therapy and it is counted as a therapy service but respiratory therapy does not appear to be considered a rehabilitation service under RCS-1.

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NASL is pleased to submit these comments to CMS and we reiterate our desire to work with the agency to more fully develop and refine this payment model. I can be reached at 202-803-2385 or cynthia@nasl.org.

Sincerely,

A handwritten signature in cursive script that reads "Cynthia Morton". The signature is written in black ink and is positioned above the printed name.

Cynthia K. Morton
Executive Vice President