August 25, 2017

Thomas E. Price
Secretary
Department of Health and Human Services

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


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

Dear Dr. Price and Ms. Verma:

On behalf of the Center for Advocacy for the Rights and Interests of the Elderly (CARIE), thank you for the opportunity to provide comments regarding the above referenced proposed rulemaking concerning new Medicare reimbursement provisions for skilled nursing facility (SNF) care. Founded in 1977, CARIE, is a non-profit advocacy organization working to improve the well-being, rights and autonomy of older adults. CARIE routinely helps older adults and their caregivers understand and resolve problems related to Medicare, Medicaid, and long-term services and supports. In addition, CARIE currently serves as a local ombudsman in Philadelphia and through this capacity serves residents in nursing facilities. Through our work, we are acutely aware of the needs, issues and problems that nursing facility residents and their families encounter.

CARIE strongly opposes the proposal since it adversely changes the Medicare benefit to encourage less (or no) therapy and shorter Medicare-covered SNF stays. While there are well-documented problems with the current reimbursement system, the proposal does not rectify these problems in that it does not fairly compensate SNFs to provide beneficiaries with needed therapy or work to improve staffing levels. If implemented, the policy change will lead to access and quality care problems for beneficiaries. The new policy will also impede the ability of SNFs to meet Nursing Home Reform Law requirements and the mandate of the Jimmo Settlement Agreement to cover maintenance therapy when skilled care is needed. Finally, the proposed policy seems misaligned with the IMPACT Act as well as CMS’ Quality Strategy’s goals. Because of the complexity of the proposed system and inadequate coverage of therapy, it may also encourage provider gaming of the system and fraud. The Center for Medicare Advocacy submitted detailed comments that describe the negative impact of this proposal as well as how the proposal undermines therapy services for SNF residents. CARIE concurs and fully endorses the Center’s comments and recommendations.
Proposal Creates New Problems for Beneficiaries

The problems with the current reimbursement system are well documented in the proposal. Exacerbating the problems is Medicare’s lax oversight of SNFs, so regardless of what reimbursement system is used, it should increase its oversight by auditing and penalizing SNFs for improper billing or upcoding when care is not provided or resident needs are not met. The reimbursement system should be changed to base payments on resident needs and conditions, and not on the current system method that bases payments on services delivered which has led to the identified problems. Unfortunately, under the proposed system, financial incentives shift and will have a negative impact on residents since it will lead to fewer services and premature discharges. As proposed, SNFs will receive higher reimbursement if they provide 15 or fewer days of Medicare coverage and only one form of therapy (not three). Medicare reimbursement will also be higher if 50-75% of a SNF’s Medicare days are billed as non-rehabilitation. In addition, Medicare reimbursement is lower for SNFs providing care to residents aged 90+, to residents receiving three types of therapy, or to residents having 31 or more days of care paid by Medicare.

Impact of Post-Hospital SNF Access

As hospital length of stays have declined, SNFs have filled a critical role in the rehabilitation and recovery of Medicare beneficiaries. Therapy is critical to help people return to their previous level of functioning and get back home. Even those who cannot return to their premorbid level of functioning benefit, as therapy helps them become as independent as possible after an injury or disease has caused a decreased ability to engage in everyday activities. Many frail older adults do not qualify for inpatient rehabilitation facilities (IRF), where three hours of therapy, 5 days per week is provided. SNFs are the only inpatient alternative for those who need rehabilitation but are too debilitated to endure the rigors of IRFs or simply do not qualify. Since SNFs will receive higher reimbursement if they provide 15 or fewer days of Medicare coverage, older beneficiaries who need longer stays and time in therapy to recover, may have difficulty accessing SNF care when they are being discharged from a hospital. SNFs may determine that certain beneficiaries may be at high risk of needing to stay more than 15 days to recover and will be reluctant to admit them. This will most likely impact frail beneficiaries who live alone, or reside with an older spouse or working caregiver. The proposed payment model encourages shorter stays so consumers may be discharged home prematurely with more limited functional ability impacting their quality of life and the ability of caregivers to care for them.

Resident Needs and Quality Care

Therapists help residents with mobility, transfers, self-care management, safety techniques, use of assistive devices and adaptive equipment, fall prevention, and other functions to improve independence and prevent future hospitalizations or injuries. Long-term residents also benefit from therapy when they experience a functional decline. Therapy can help them to regain strength and previous ability improving their sense of dignity and reducing the amount of assistance needed by staff. Providing insufficient therapy, or reducing the amount of therapy provided to residents, will lead to an increase in hospitalizations, injuries, and permanent admissions to nursing facilities.

The proposal does not create a system of checks and balances to ensure residents get the therapy they need. Of particular concern is that one therapy may be provided in exclusion of the other since SNFs will be reimbursed the same regardless of whether they provide PT or OT services. Even more concerning, residents may not receive any therapy since there are no safeguards in RCS-I to hold SNFs accountable for providing appropriate therapy. In addition, RCS-I does not clearly define when a significant change assessment is needed. With the elimination of the other periodic assessments, the significant change assessment may be more critical to reflect changes in the resident’s needs. The RCS-I also may not fully consider mild cognitive impairment, which is embodied in the ability to perform ADLs and IADLs. CARIE recommends that RCS-1 be adjusted, in line with the IMPACT Act, to ensure attention to cognition. All beneficiaries, especially the most vulnerable with multiple chronic conditions, who risk further decline or injury without therapeutic services, should have access to medically necessary services and be afforded the opportunity to live with dignity in the most independent way possible.

In conclusion, CARIE strongly urges CMS to reject the proposed reimbursement model and to develop a new system to reimburse SNFs to provide the high quality of care that is required by the Nursing Home Reform Law and Jimmo. The proposed change would negatively impact consumers seeking SNF care and will reduce the delivery of therapies and impact the quality of care for residents who already typically receive low levels of nursing and therapy services. As required by law, CMS should ensure residents receive all the nursing care and therapy services they need.

Sincerely,

Diane A. Menio
Executive Director