

March 9, 2017

Thomas E. Price, M.D.
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dr. Price,

Congratulations on your recent confirmation as Secretary of Health and Human Services. As the largest trade association in the country representing skilled nursing facilities (SNFs) and assisted living communities, the American Health Care Association and National Center for Assisted Living (AHCA/NCAL) looks forward to working with you to improve the lives of the millions of residents in the 13,000 long term and post-acute care facilities we represent.

It is a privilege to care for our country's elderly and frail citizens. Providers in our space have dedicated themselves to quality, improving the care Americans receive in skilled nursing facilities on almost every metric. Over a four-year period, the national averages have improved for 17 of the 18 quality measures the Centers for Medicare and Medicaid Services (CMS) collects and reports on Nursing Home Compare. AHCA's Quality Initiative began five years ago and has resulted in a 32.9% reduction in antipsychotic prescription use. Our members also have reduced rehospitalizations by 8%, which translates into approximately 80,000 fewer rehospitalizations and a savings of \$828 million in hospitalization costs.

Despite these successes, the pivotal role we play in taking care of this important population, and the growing need for our services as our nation ages, there is a sad reality: long term care is being strangled by Medicaid underfunding, Medicare cuts, and over-regulation. Medicaid currently underfunds SNFs an average of 89 cents for every dollar of care provided. On top of this, over \$27 billion has been cut from our Medicare reimbursement in recent years. These shortfalls and cuts have resulted in MedPAC finding the "all-in" margin for SNFs to be 1.6%

Combined with reimbursement cuts and Medicaid shortfalls, numerous and burdensome regulations are threatening a profession that is already on the brink of failure. Slim margins mean that any regulatory hiccup or lawsuit can result in a negative margin and force providers to close their doors. Given our current reality, this profession simply cannot shoulder the current array of costly regulations for much longer.

We need some regulatory relief to continue our mission of improving lives of those in our facilities. We are already the most regulated profession in the country. This includes numerous requirements and demonstrations enacted unilaterally by the previous

administration that simply ignore how care is provided in our facilities. In addition, a punitive approach by survey teams across the country has threatened to shut down even the best operators in our profession.

We are committed to taking care of the Greatest Generation and beyond, but we need help. Fortunately, there are some quick and relatively easy fixes within HHS and CMS authority that would provide us the breathing room to focus on our passion. We respectfully request that you consider some of the following changes.

Issue an annual SNF Payment Rule with no drastic alterations to current payment policy.

We are concerned about some efforts taken under the previous administration to drastically alter the way in which SNFs receive Medicare reimbursement. The plan lacks a complete CMS analysis of the operational details and CMS has not shared sufficient data or information for stakeholders to fully understand the impacts on SNFs and the people they serve. The 2018 payment rule offers the opportunity to stop this potential threat.

This payment system, developed by career staff at CMS, would shift SNFs into a characteristic-based payment system. Such a system is not inherently bad, but as currently conceived would be harmful to our residents. In addition, it would be particularly difficult for smaller operators and operators in rural areas to implement. It is overly complex, adds more federal bureaucratic complexity to the SNF payment system, and would make managing spending for the government and care for people needlessly complicated. This payment proposal completely changes payment philosophy and further erodes razor-thin SNF margins. We ask that you put this work on hold until the system can be further evaluated.

We also ask that you work with us on payment changes that will benefit our residents and save the government money. We have developed a payment reform model that achieves both. We've been working with Republican leadership in both the Senate and House and look forward to working with you on this effort as well.

Reverse group and concurrent therapy reporting changes.

The 2018 annual payment rule can be used to reverse prior rule changes that have effectively limited the ways in which SNFs deliver therapy. During the Bush administration, therapy services in SNFs were delivered based upon the judgment of professional therapists and attending physicians. In addition to individual one-on-one therapy, CMS acknowledged that concurrent or group therapy was also effectively delivered. Research shows that in some situations, residents prefer the socialization of a group and it is very effective. Unfortunately, under the Obama administration, CMS dictated how therapy should be delivered, making it virtually impossible to provide group and concurrent therapy in a cost-effective manner. The net result is that nearly all therapy is now one-on-one. Not only is this costly—in some markets it has also created shortages of therapists.

Specifically, we request the following:

1. Reversal of the “Concurrent Therapy” MDS reporting requirements change, finalized in the FY 2010 SNF PPS final rule (74 FR 40228), and as implemented with the introduction of the full RUG-IV system in FY 2011.
2. Reversal of the “Group Therapy” MDS reporting requirements change, as finalized in the FY 2012 SNF PPS Final Rule (76 FR 48486), and as implemented in FY 2012.

To address CMS and Office of Management and Budget concerns about therapy utilization, AHCA suggests two protections. First, CMS would specify that no more than 25 percent of therapy could be delivered using concurrent therapy as it has done for group therapy since the onset of the SNF PPS in 1998. Second, no more therapy could be delivered in subsequent years than in the preceding year other than increases associated with growth in the patient population. AHCA has specific language suggestions and would be pleased to share such language. Finally, as an additional patient-specific protection, SNFs would be monitored on the adequacy of their care, including therapy, under the IMPACT Act Quality Reporting Program measures associated with function and return to community.

AHCA agrees the existing skilled nursing facility prospective payment system (SNF PPS) is in need of modernization. However, since these therapy reporting changes did not to improve the SNF PPS while increasing provider costs, the Association respectfully requests that CMS be directed to work with the profession on how best to reverse these changes and create needed flexibility for patients and providers. Meanwhile, AHCA will continue to be an active partner in re-thinking SNF Medicare payment particularly in the context of the IMPACT Act unified, cross-setting post-acute care payment system. DHHS is due to release its response to MedPAC’s conceptual report. AHCA stands ready to aid DHHS in its efforts relative to bigger picture, substantive change.

We ask that you restore the Bush administration rules relating to reimbursement for skilled nursing facility rehabilitation. This would allow concurrent and group therapies where they are clinically appropriate and restore prior protections on its use, assuring that most therapy would still be one-on-one. This move would immediately reduce unneeded costs and solve therapist shortage issues where they exist.

Revise the survey and certification process, particularly with respect to Civil Monetary Penalties.

The survey and certification process for the SNF setting is much more extensive than for hospitals, home health, and other Medicare providers. Any violation in the SNF setting, no matter how small, is treated as a violation of the requirements of participation in Medicare and Medicaid and puts the SNF on a termination track from these programs. These violations can also result in large Civil Monetary Penalties (CMPs).

Problems for providers begin with the way the CMS currently oversees its regional offices. The regional offices, not CMS program staff, have authority to issue CMPs. As such, we have seen the regional offices act inconsistently with CMS policy, while CMS program staff lack the current authority to change or modify regional office decisions.

The use of CMP's is out of control. Attached you will find a chart that shows that in the second half of 2016 CMS imposed them at historically high levels (Appendix 1). The annualized rate of \$150 million in CMP's a year is strangling the industry. What is so frustrating about this is that it is occurring at the very time that we have so dramatically improved quality. We have attached a number of charts that demonstrate this as well (Appendix 2). We believe we should be rewarded for our efforts and instead CMS is punishing us.

We have seen a dramatic increase in CMPs being retroactively issued and used as a punishment. The purpose of issuing a CMP is to create a financial incentive to immediately resolve a jeopardy situation that may cause further adverse events to residents. However, recent CMS sub-regulatory guidance to the regional offices expanded the use of CMPs for lower level deficiencies that did not result in any resident harm. This guidance also allowed CMPs to be applied retrospectively in a punitive nature rather than prospectively as an incentive to fix the problem cited. This, coupled with the lack of oversight by the CMS program staff, has resulted in serious misuse of CMPs. This practice is counter to the original cause for using CMPs and is generating immense financial strain for even some of the highest-quality care providers.

This also has had an unintended effect on SNF training programs for Certified Nursing Assistants (CNAs), who provide a majority of care in SNFs. These training programs are revoked for two years when CMPs of certain amount are issued. The increase in the use of CMPs retrospectively and for citations unrelated to resident harm has resulted in many CNA training programs being revoked. These programs are essential to help meet the staffing shortages in SNFs. Revocation of these programs is the death knell to a SNF, where staffing shortages are already endemic in our profession.

To resolve this issue, we ask that you delegate nursing facility survey and enforcement responsibility to CMS Office of Clinical Standards and Quality and the Survey and Certification Division, not the Regional Offices. Additionally, Regional Offices and State Survey Agencies should be incentivized by improved outcomes for the SNFs in their region, not on the number and severity of deficiencies and CMPs. Finally, we ask that CMS issue a new Survey and Certification policy memorandum that specifies CMPs can no longer be retroactive nor used exclusively to justify the suspension of CNA training programs (replacing S&C: 16-31-NH, revised 07.29.16.). We can provide more details to you and your staff to effectuate this ask.

We believe survey relief is a two-step process. You would greatly assist the immediate need with the ideas just discussed. The second step is a longer-term solution. The current system is both punitive and combative. We need a system that is collaborative. We need fundamental change. There are a couple of ways that you could achieve this. One is to turn regulation back to the states. As CMS turns more payment flexibility to the states, it's time to do the same thing with respect to regulation. A major part of the problem has been federal employees overriding and demanding punitive treatment at the state level. A second way to achieve collaboration is to take the incentives to punish away from survey teams and instead incentivize them towards quality outcomes in buildings. The goal

should be great treatment of patients, not to shut buildings down. We know you understand this and look forward to working with you on solutions.

Modify and phase-in the recent Requirements of Participation rule.

CMS issued a sweeping rule that became effective in November 2016 that updated the SNF Medicare and Medicaid Requirements of Participation. The rule will place an enormous cost on the SNFs. CMS, who grossly underestimates provider implementation costs, predicts the new rule will cost SNFs \$53,111 in the first year and \$55,388 every year thereafter. Nationally, this amounts to over \$831 million in the first year and over \$735 million in recurring annual cost.

The new requirements will be implemented and enforced in three phases: November 2016, November 2017 and November 2019, with plans to completely change the survey inspection process in November 2017. While we support a number of positive changes in the Requirements of Participation that will improve resident outcomes, there are many other changes that are unnecessary, overly burdensome, and will get in the way of resident care. Some changes unnecessarily micromanage operations, typified by the requirement SNFs develop a policy and procedure around handling lost dentures.

CMS is rushing to issue subregulatory guidance, (i.e., interpretative guidance (IG)), for all the new requirements, which will be incorporated into a new survey inspection process in November 2017. The early drafts of the IGs shared with stakeholders frequently go well beyond the regulatory authority, have numerous mistakes, and use confusing terminology and descriptions. However, CMS staff state that they must rush to finalize these IGs in the coming weeks in order to meet a timeline to incorporate them into the new survey process that will also be rolled out in November 2017.

We ask that CMS delay the implementation of the new survey process while CMS issues a new proposed rule for the Requirements of Participation, including a new phase-in timeline and specific changes to sections of the rule that are overly burdensome and do not help with resident care. Sections that should be modified or eliminated include the ban on binding arbitration, an annual in-depth facility assessment to establish staffing requirements, behavioral health resources to take care of the chronically mentally ill (e.g. schizophrenia), release of peer-review and root cause analyses to surveyors, conversions of room sizes and bathrooms whenever construction/renovations are made, and extensive documentation by physicians on their prescribing decisions. We are happy to work with your team and CMS staff to provide more specific suggestions.

To alleviate the costly, serious implementation challenges that many providers are facing, the rollout of the new survey process planned for November 2017, including the finalization of the Interpretive Guidance as well as the phase-in enforcement of the current Requirements of Participation, should be suspended until the new rule can be issued, commented on, and finalized.

Suspend the flawed Medicare outpatient therapy functional reporting requirements.

Currently, all Medicare outpatient therapy providers are required to submit non-standardized information about therapy services that have no proven benefit for patient care or policy improvement. The regulations, issued by CMS in November 2012, stem from the Middle Class Tax Relief and Jobs Creation Act of 2012 ([MCTRICA](#)), which required the Secretary to implement “a claims-based data collection strategy” to aid efforts reforming Medicare payments for outpatient therapy services.

CMS itself has acknowledged that this “Functional Reporting” adds to provider burden and does not permit meaningful analysis comparing patient function or the effectiveness of care between providers or patients. CMS indicates that this program is only the first step, stating, “We expect that through future notice and comment rulemaking we will be able to enhance the system.”

Despite our repeated requests through public comments, CMS has not presented any evidence that the data is being analyzed and has not offered any proposed enhancements to improve the usefulness of the data collected to inform payment policy improvements. It is unacceptable for providers to be burdened with such a flawed and complex data submission process for no discernable policy benefit. Informing policy improvement was the legislative intent.

We support the submission of appropriate standardized outpatient therapy functional assessment data to help inform payment policy improvements. However, the current process must be suspended until it can be fixed. We propose that during the data submission pause, CMS work with providers to develop a meaningful patient-centered functional reporting process through the rulemaking process that would: 1) produce meaningful information to inform payment policy; and 2) that would align with the existing Improving Medicare Post-Acute Care Transformation (IMPACT) Act assessment items.

Amend the new way in which staffing data is collected, the Payroll Based Journal.

CMS is required to collect staffing levels of hours worked every day for every shift for every employee, contractor and consultant in the SNF setting based on payroll information as part of the Affordable Care Act. AHCA originally supported this program, called the Payroll Based Journal (PBJ). However, CMS sub-regulatory guidance has resulted in an unnecessarily expensive and technical submission process that does not provide accurate or useful data. Without running a pilot, CMS mandated that all SNFs start submitting the PBJ data by November 2016. While most SNFs submitted data, it was often incomplete and inaccurate due to CMS’s rushed timeline and complex sub-regulatory guidance.

There are several decisions CMS made under the previous administration when implementing the PBJ that don’t make sense.

- CMS decided to require the hours of evening shift workers, who work 11 pm to 7 am, be divided by calendar day—a departure from current professional standards that create increased costs to change both payroll and time and attendance systems.

- Exempt, salaried employees who work more than 40 hours in a workweek must be paid overtime for these additional hours to be counted toward staffing totals. Many exempt nurses and other health care providers work more than 40 hours a week and not allowing these hours to be collected will make the hours of nursing care in SNFs look artificially low. Time and attendance systems in place in many facilities as well as requirements to track staff working each shift provide an auditable method to track exempt employees working more than 40 hours.
- CMS plans to use the census of residents on the last day of the month to calculate the staffing hours per patient per day for each day in the month. This will be inaccurate for many centers, especially when census is not constant throughout the month or when the last day of the month falls on a weekend or high census day. We recommend using daily census data that is readily available.
- CMS has indicated that when a facility changes ownership, they will be considered to have turnover of all staff unless they can get payroll records from the prior owner, which is nearly impossible to achieve.
- The complexity of the system has generated numerous questions from our members but they are unable to speak to anyone at CMS to help solve their problems. They are only able to submit questions by email. We ask that CMS put together a reasonable help desk that providers can call to get help.

In light of these concerns, we ask that you suspend the implementation and use of the Payroll Based Journal until the technical data collection issues noted above and policies for reporting data are corrected to reflect current standards of practice. We have offered on numerous occasions to CMS to help pilot test the system to work out these technical problems but they forged ahead without a pilot test resulting in numerous problems.

Additionally, providers need more assistance when implementing a complex program like this. CMS needs to provide feedback reports to providers on the system so that they can correct issues in their submissions. Currently, the validation reports the system produces are vague and require providers to spend a large amount of time analyzing the data submitted to identify any flaws that should be corrected. These validation reports need to be revised so that they can provide more details on the nature and the instance of the errors that are causing files to be rejected in the system. We also ask that create a hotline for providers to call with technical questions when they are having trouble submitting data.

Allow observation stays in a hospital to count toward the three-day hospital stay requirement for a SNF benefit.

We believe that CMS can eliminate an access barrier for thousands of Medicare beneficiaries who are held in hospitals under *outpatient* observation. Current law requires that a beneficiary have at least three *inpatient* days in order to qualify them for Medicare coverage of a stay in a SNF. Beneficiaries are blind to this designation, as observation

patients often receive care and services identical to those of inpatients; the only difference is that observation stays do not qualify toward the three-day requirement, even if the patient requires SNF care. Additionally, beneficiaries are often unfairly burdened with large out-of-pocket expenses that otherwise would have been covered by Medicare. It is obvious in looking at the intent of the Medicare statute that any three-day stay should qualify a Medicare beneficiary for needed SNF care. There are tens of thousands of Medicare beneficiaries who get tangled in this each year. Beneficiaries often incorrectly assume that because they stayed in a hospital for three days, regardless of their classification, they are entitled to their SNF benefit, only to learn that Medicare will not cover it because of this arbitrary classification.

It is clear that CMS can solve this. We have provided CMS with a legal opinion that indicates the agency has this authority; we would be happy to provide it again. We have tried multiple times to convince the prior administration that it could fix this challenging problem, but it continued to maintain that it did not have the authority under their specific legal interpretation. We disagree and ask you to direct CMS to resolve this issue in the next rule-making cycle.

Halt the implementation of the CJR/EMP rule.

We applauded your position on this rule when you were a Member of Congress and stand ready to work with you to continue to limit overreach by the Center for Medicaid and Medicare Innovation. The Advancing Care Coordination through Episode Payment Models final rule, currently at OMB, would implement a mandatory demonstration of three new payment models, two cardiac and one orthopedic, in dozens of markets across the country. As proposed, the rule would run for almost five years, from 2017-2021.

We agree with your September 30, 2016, letter to Former CMS Director Slavitt that this rule is yet another example of third parties coming between patients and caregivers. If implemented, the varied effect on markets and mandatory nature of this demonstration will leave SNFs and beneficiaries little time to adapt. Many of these mandatory demonstrations across a wide swath of markets already have adversely affected the way in which our members provide care. We appreciate your commitment to ensuring patient and beneficiary flexibility by limiting these mandatory demonstrations.

To help resolve the above issues, we ask that CMS identify a number of voluntary providers with diverse backgrounds (e.g. large multi-facility organizations, independent single facilities, etc.) to pilot test and revise the system.

We believe the above requests fall under the authority of HHS and CMS and are aligned with the goals of the administration. Executive Order 13777 of February 24, 2017 outlines steps agencies should take to “alleviate unnecessary regulatory burdens placed on the American people.” You can find a chart detailing where each of these changes falls within the administration’s regulatory reform agenda (Appendix 3).

We appreciate your consideration of these requests. We are prepared to continue providing amazing care and building on our past success. Our commitment to you is that we will continue our quality efforts on an unprecedented scale. Whether caring for long

stay residents or providing therapy for short-stay resident, SNFs are the lowest cost, highest quality setting. We can continue to deliver this solution, but we need the federal government to work with us on the regulatory side. Together, we are the solution when it comes to taking care of this important frail and elderly population.

Sincerely

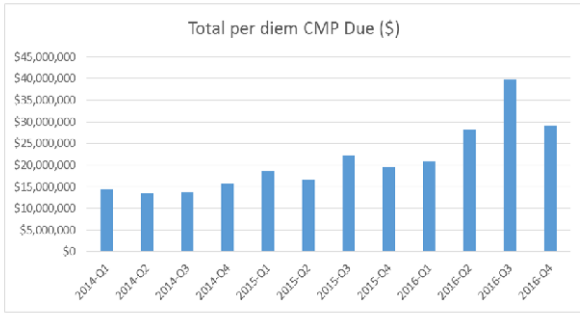
A handwritten signature in black ink, appearing to read "Mark Parkinson". The signature is fluid and cursive, with a small dot at the end.

Mark Parkinson
President and CEO

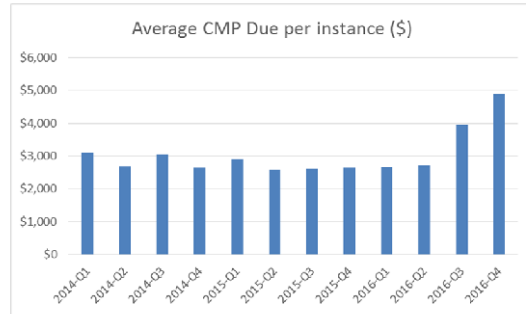
Appendix 1

Rise in Civil Monetary Penalties

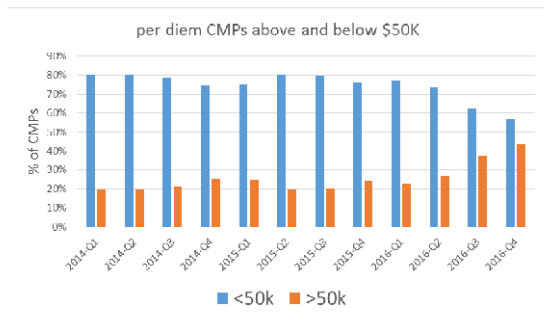
Trend in Total CMP Due When Issued as Per Diem



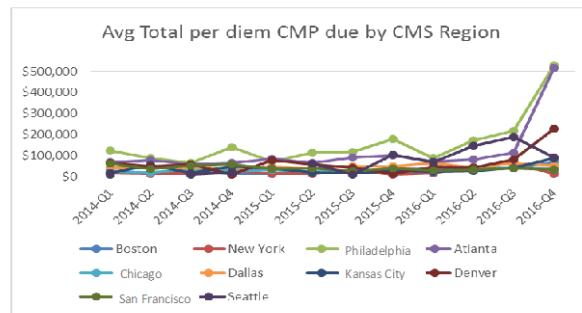
Trend in Total CMP Due When Issued as Per Instance



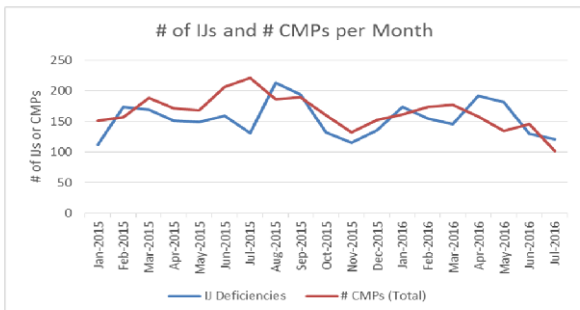
Trend in Total CMP Per Diem Above and Below \$50K



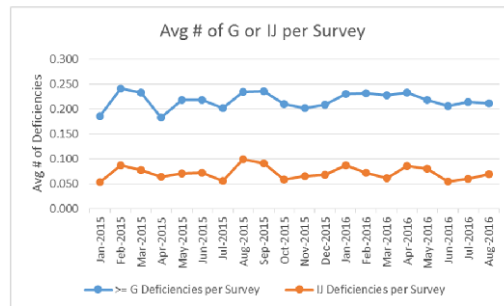
Trend in Average Per Diem CMP Due by CMS Region



Trends in Number of IJs and CMPs Each Month (Past 18 Months)



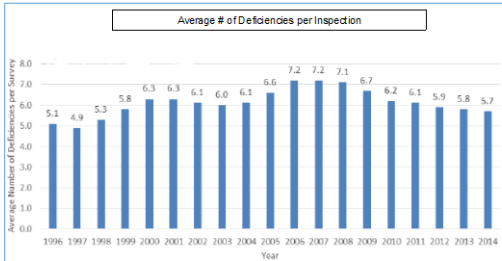
National Average Number of G or IJ Per Survey Visit



Note: Aug and Sept data is incomplete and appears to represent about 40% of data. Thus, the results may change when the remaining 60% of data is received.

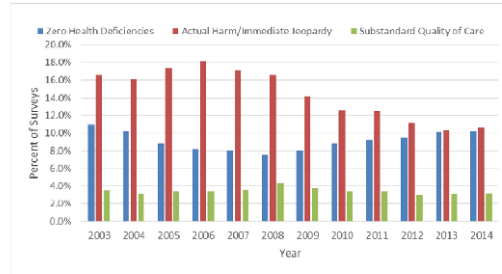
Appendix 2 Skilled Nursing Quality is Improving

Average Number of Deficiencies are Decreasing



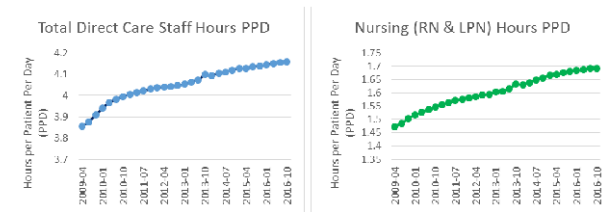
From CMS Publication: Center for Clinical Standards & Quality: Nursing Home Enforcement Reports Through December 31, 2014. Published S&C memo June 2016 (S&C: 16-27-NH) pg 2

Number of SNF Deficiency-Free Surveys are Increasing



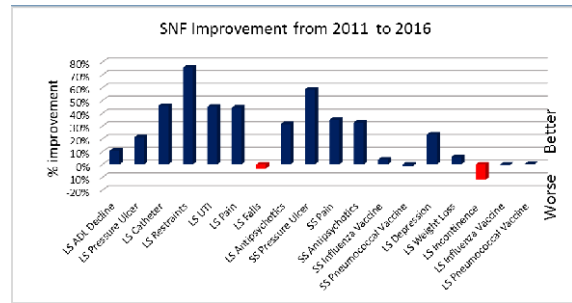
From CMS Publication: Center for Clinical Standards & Quality: Nursing Home Enforcement Reports Through December 31, 2014. Published S&C memo June 2016 (S&C: 16-27-NH) pg 5

Staffing Levels Have Been Increasing



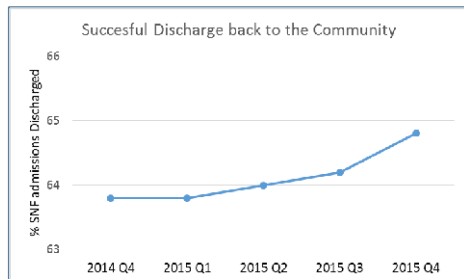
From CMS Nursing Home Compare on staffing hours collected by CMS during their onsite annual inspection

Quality Outcomes are Improving or Remaining High for 16 of the 18 Quality Outcome Measures Reported on Nursing Home Compare

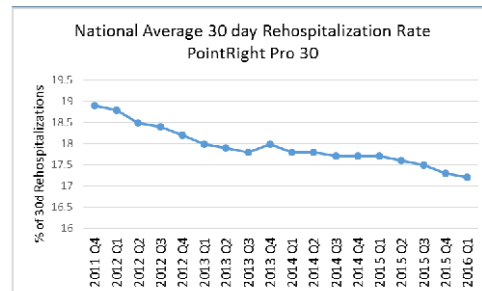


Data from CMS Nursing Home Compare using the Quality Measures (QM) from electronic medical records (EMR) mandated that all SNFs use. Comparing QM rates from 2011 Q4 to 2016 Q2

Increase in Discharge Back to the Community



Decrease in Rehospitalizations



Data from NQF endorsed PointRight Pro 30 risk adjusted rehospitalization measures that captures all rehospitalizations for all payor types within 30 days of admission to a SNF from a hospital.

Appendix 3

How requested regulatory changes reflect the goals of Executive Order 13777 (February 24, 2017)

Regulatory Change	Section of Executive Order					
	3(d)(i)	3(d)(ii)	3(d)(iii)	3(d)(iv)	3(d)(v)	3(d)(vi)
Issue an annual SNF Payment Rule with no drastic alterations to current payment policy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	
Revise the survey and certification process, particularly with respect to Civil Monetary Penalties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Allow SNFs to deliver group and concurrent therapy again.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Modify and phase-in the recent Requirements of Participation rule.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Suspend the flawed Medicare outpatient therapy functional reporting requirements.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Amend the new way in which staffing data is collected, the Payroll Based Journal.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Allow observation stays in a hospital to count toward the three-day hospital stay requirement for a SNF benefit.		<input type="checkbox"/>	<input type="checkbox"/>			
Halt the implementation of the CJR/EMP rule.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	

From Executive Order 13777, posted on pg. 12286 of the Federal Register / Vol. 82, No. 39:

(d) Each Regulatory Reform Task Force shall evaluate existing regulations (as defined in section 4 of Executive Order 13771) and make recommendations to the agency head regarding their repeal, replacement, or modification, consistent with applicable law. At a minimum, each Regulatory Reform Task Force shall attempt to identify regulations that:

- (i) eliminate jobs, or inhibit job creation;
- (ii) are outdated, unnecessary, or ineffective;
- (iii) impose costs that exceed benefits;
- (iv) create a serious inconsistency or otherwise interfere with regulatory reform initiatives and policies;
- (v) are inconsistent with the requirements of section 515 of the Treasury and General Government Appropriations Act, 2001 (44 U.S.C. 3516 note), or the guidance issued pursuant to that provision, in particular those regulations that rely in whole or in part on data, information, or methods that are not publicly available or that are insufficiently transparent to meet the standard for reproducibility; or
- (vi) derive from or implement Executive Orders or other Presidential directives that have been subsequently rescinded or substantially modified.