American Hospital Association™
Advancing Health in America

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June 9, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Room 445-G
Washington, DC 20201

CMS—1737—P: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Federal Fiscal Year 2021

Dear Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including 750 hospital-based skilled-nursing facilities, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2021 proposed rule on the SNF prospective payment system (PPS).

The AHA appreciates CMS's streamlined proposed rule, which allows SNFs and their partners to focus on local COVID-19 responses.

In addition, our SNF members report that the Patient-driven Payment Model (PDPM), the new SNF case-mix system implemented on Oct. 1, 2019, appears to provide greater flexibility for them to meet the demands of the COVID-19 pandemic. In particular, the extra costs associated with treating COVID-19 patients are generally better captured (although still not fully) through PDPM's payments. Our SNF members attribute this to the basis of their payment being a composite profile of each patient's medical complexity, rather than largely driven by the quantity of therapy minutes.

COVERING COVID-19 TESTING COSTS IN SKILLED NURSING FACILITIES

The proposed rule calls for input on new items to exclude from SNF PPS bundled payments, those of which that are unusually high-cost and rare. **As such, we urge CMS to support outside of standard SNF PPS payments additional funds for SNF COVID-19 testing.** While COVID-19 testing does not fall in one of the current four consolidated billing categories (chemotherapy items; chemotherapy administration services; radioisotope services; and customized prosthetic devices), it certainly satisfies the key criteria of being rare and high cost. Further, it clearly fits the spirit of the policy, which recognizes that some important SNF costs do not fit within the range of SNF PPS payments. Given this lack of policy alignment, and the essential need for widespread, SNF-based COVID-19 testing, CMS should separately cover the cost of this testing for the emergency period's full duration.

While PDPM recognizes SNF patients primarily admitted due to positive COVID-19 status under the medical management clinical category, in general, this case-mix element's payment is among the lowest. Yet, COVID-19-positive patients are widely acknowledged to generally require substantial additional clinical and other resources, such as:

- COVID-19 testing (in some cases, multiple tests per patient);
- additional physician patient oversight;
- additional nursing care, including higher-level nursing;
- additional diagnostics and non-therapy ancillary services;
- the creation of isolation space, which often involves new construction;
- personal protective equipment for staff and patients;
- personnel to engage with local and state emergency planners and other policymakers, including CMS and the Centers for Disease Control (CDC), both during and following this pandemic;
- additional personnel time to meet new COVID-19 reporting requirements to families and the CDC;
- facility deep-cleaning costs, including transportation costs to temporarily relocate patients during the cleaning process;
- external support for infection control protocol evaluation and improvement; and
- external support for staff training on infection control and other pandemic-driven process changes, both during and following the pandemic.

While a portion of these costs have been supported with much-appreciated emergency funds, COVID-19 testing remains a particularly costly ongoing need, with the added expectation that it will resurface during future pandemics.

CMS has asked nursing homes to test workers weekly, but has not made it a requirement. In addition, CMS expects *all* nursing home residents to get a baseline test.

The industry estimates that each test costs approximately $100, and, unfortunately, many employers and insurers have declined to cover these costs. Further, the AHA estimates that testing all 3 million workers and residents just once would cost $672 million. Understandably, providers and local emergency planners are struggling in this demanding, but confusing, environment. Given this convergence of urgent need and overwhelming uncovered costs, we turn to CMS to help offset the cost of these essential tests.

The proposed rule recommends an Oct. 1, 2020, effective date for any newly approved consolidated billing items. However, quick action is needed with regard to new funding for COVID-19 testing in SNFs, similar to the greatly accelerated HCPCS approval process used to authorize new codes for COVID-19 testing. As such, we support a retroactive effective date – Jan. 27, 2020, the first date of the current public health emergency.

SNF QUALITY REPORTING PROGRAM (QRP) AND VALUE-BASED PURCHASING (VBP)

In recognition of the impact of the pandemic on standard operations, we believe it was appropriate for CMS to exclude data from the first two quarters of the 2020 calendar year when calculating SNF value-based purchasing performance. We agree these time periods will not be fully representative of SNF performance. At the same time, the exclusion of these data could have impacts over multiple fiscal years, given that the SNF VBP program includes both a baseline and a performance period.

We urge CMS to conduct measure reliability analyses using truncated performance periods to ensure sufficient data for accurate performance calculation, and to make public any results of such an analysis. Basing payment adjustments on unreliable data would be highly problematic. Furthermore, as the COVID-19 pandemic evolves, CMS will need to carefully evaluate whether excluding additional data periods may be warranted.

Thank you for the opportunity to comment on this proposed rule. Please contact me if you have questions or feel free to have a member of your team contact Rochelle Archuleta, AHA's director of policy, at rarchuleta@aha.org.

Sincerely,

Thomas P. Nickels
Executive Vice President