425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Francis J. Crosson, M.D., Chairman
Jon B. Christianson, Ph.D., Vice Chairman
James E. Mathews, Ph.D., Executive Director

June 15, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-1696-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2019, SNF Value-Based Purchasing Program, and SNF Quality Reporting Program" in the *Federal Register*, vol. 83, no. 89, p. 21018 (May 8, 2018). We appreciate your staff's ongoing efforts to administer and improve the payment system for skilled nursing facilities, particularly given the many competing demands on the agency staff's resources.

The Commission's comments are organized into five sections: the update for fiscal year (FY) 2019, quality reporting, value-based purchasing, revisions to the case-mix classification system, and changes to the patient assessment and therapy requirements.

Update to the proposed rates under the SNF PPS

The proposed rule increases Medicare's payment rates for skilled nursing facilities (SNFs) by 2.4 percent, as required by the Bipartisan Budget Act of 2018. On net, Medicare's payments to the SNF sector are estimated to increase by $850 million during FY 2019. To comply with the requirements of the IMPACT Act, beginning in fiscal year 2018 the payment update for providers failing to submit data required for the quality reporting program (QRP) will be reduced by 2 percentage points, which may, in some years, result in payments that are lower than the prior year's payments (a negative update).

Comment

The Commission understands that the Balanced Budget Act of 2018 requires CMS to update the SNF prospective payment system (PPS) rates by 2.4 percent. That said, after reviewing many factors—including indicators of beneficiary access, the volume of services, the supply of providers, and access to capital—the Commission recommended in its March 2018 report that

the Congress eliminate the updates to SNF payments for FY 2019 and FY 2020. In 2016, the aggregate Medicare margin for freestanding SNFs was 11.4 percent, the 17th consecutive year that the aggregate Medicare margins exceeded 10 percent. This high level of payments relative to the cost to treat beneficiaries indicates that Medicare's payments are more than adequate to accommodate cost growth.

CMS is seeking comments on the reduction to the payment update even if it means that the update could be negative (a reduction). In general, the Commission does not support paying for reporting when this would result in increased payments—that is, rewarding providers for furnishing the information necessary for Medicare to assess the value of the care it purchases. That said, the Commission supports the proposed reduction to the payment update for any provider failing to submit information needed for the QRP. As Medicare moves to value-based purchasing, information needed for the QRP is critical to determining if Medicare's payments are adequate to ensure high-quality, accessible care for its beneficiaries.

SNF quality reporting

In October 2017, CMS launched the Meaningful Measures Initiative, aimed at improving patient outcomes and reducing burden by using "a parsimonious set of meaningful measures" in quality reporting and value-based purchasing programs for patients, clinicians, and providers. As a part of the initiative, CMS identified 19 high-priority areas for quality measurement, with a focus on improving patient outcomes (e.g., admissions and readmissions to hospitals, patient's experience of care, transfer of health information, and preventive care). The Meaningful Measures Initiative represents a new approach to quality measurement in Medicare to foster operational efficiencies and reduce costs, including the collection and reporting burden, while producing quality measurement that is more focused on meaningful outcomes.

In the proposed rule, CMS proposes to increase the number of years of data used to calculate the discharge to community and Medicare spending per beneficiary measures (from one year to two years). This will increase the number of SNFs with adequate data for public reporting.

Comment

The Commission has recently formalized a set of principles for measuring quality in the Medicare program. Overall, quality measurement should be patient oriented, encourage coordination, and promote delivery system change, while not being unduly burdensome. The Commission asserts that Medicare quality incentive programs should use a small set of outcome, patient experience, and value measures to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, accountable care organizations (ACOs), and fee-for-service (FFS) in defined market areas, as well as those cared for by specific groups of providers or clinicians. The goals of CMS's Meaningful Measures Initiative—to improve patient outcomes and reduce burden—align with the Commission's principles. As CMS continues to revise Medicare quality programs with a focus on meaningful

measures, we encourage CMS to use a uniform set of population-based outcome measures across settings and populations.

The Commission supports the use of a second year of data to expand the number of providers for which quality and resource use measures can be reported. So that providers are not unduly judged by “old” performance, CMS could consider giving more weight to the most recent performance year.

The Commission questions how CMS determines the minimum counts for its quality and resource use measures. Minimum counts for accurate measures refers to the number of observations needed to have reasonable confidence that the estimate is a good representation of the provider’s “true” performance, which will be unknown due to imperfect risk adjustment and some inherent randomness in the outcome for any given patient. The minimum counts should vary by measure to reflect the amount of variation across observations within a provider and, for value-based-purchasing (VBP), across providers. A lot of variation within a provider indicates large confidence intervals around estimates of its “true” performance and should prompt requirements for a higher minimum count.

The Commission’s work on a SNF measure of discharge to community found that 25 stays (the minimum count that CMS will use for this measure) is sufficient to calculate an accurate representation of a provider’s performance. However, our work on a uniform Medicare spending per beneficiary (MSBP) measure for all post-acute care providers found that the minimum count to be used by CMS for this measure (20 stays) would not ensure accurate measures. The confidence intervals for this measure were large and would become acceptably narrow only with higher minimum counts. When measures are not accurate, a particular problem for low-volume providers, the risk of misclassification of performance is high (for example, a provider could appear to have a “high” MSPB when, in fact, its performance is not statistically different from average). In addition, a low-volume provider’s performance is likely to vary considerably from year to year. The Commission urges CMS to reconsider its approach to establishing minimum counts (and the reliability threshold it uses) to ensure accurate measures. We support CMS’s use of strategies, such as pooling across years, to increase the reliability and accuracy of quality measures.

Skilled nursing facility value-based purchasing program (VBP)

The Protecting Access to Medicare Act (PAMA) of 2014 requires the Secretary to implement a value-based purchasing (VBP) program for SNFs beginning October 1, 2018. The law requires the VBP program to vary Medicare payments for SNF services based on a measure of all-cause, all-condition 30-day readmissions to hospitals and to replace this measure as soon as practicable with a potentially preventable readmission measure. In assessing SNF performance, the Secretary is required to rank each facility’s performance on its readmission rates and consider the higher of a SNF’s improvement or attainment. In FY 2019, the adjusted federal per diem rate applicable to each SNF will be reduced by 2 percent to fund the VBP incentive payments for that

year. The total amount of incentive payments distributed to SNFs will be 60 percent of the total amount withheld from SNFs' Medicare payments for that year.

CMS has been reviewing public comments on the issue of accounting for social risk factors in CMS's VBP and QRP received through the FY 2018 proposed rulemaking process, as well as reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine. CMS continues to consider options to address inequity and disparities in VBP programs.

In the FY 2019 proposed rule, CMS discusses proposed scoring policies for SNFs without sufficient baseline quality data (i.e., SNFs with low volume, defined as fewer than 25 eligible stays). For a SNF without sufficient baseline data, CMS proposes to assign a performance score based on attainment only, not on attainment and improvement, using one of two options. The first option would assign a score that results in a value-based incentive payment amount that is equal to the adjusted federal per diem rate that the SNF would have received for the fiscal year in the absence of the VBP. The second option would assign a score that would result in a value-based incentive payment percentage of 1.2 percent, or 60 percent of the 2 percent withhold, which essentially treats the low-volume SNF's performance as average.

Comment

The Commission has recommended that Medicare link payment to quality of care to reward accountable entities and providers for offering high-quality care to beneficiaries. In the Commission's work on a unified PPS to span the four post-acute care (PAC) settings, we have discussed the need for a PAC value-based purchasing policy that would tie a portion of a provider's payments to its performance on quality and resource use. Consistent with the Commission's principles for quality measurement described in our June 2018 report to the Congress, a PAC VBP should use a small set of outcome, patient experience, and value measures to assess the quality of care across populations and PAC settings. The Congress and CMS can consider a unified VBP program that incorporates a set of population-based measures like Medicare spending per beneficiary, patients' overall rating of care, and discharge to the community, in addition to readmissions. Until a unified payment system is in place, CMS should continue to improve each PAC setting's individual payment system and VBP. For SNFs, CMS should announce a certain date by which the VBP will begin using the potentially preventable readmissions measures, in place of the all-cause readmission measure.

The Commission supports CMS's continued consideration of how to account for social risk factors in Medicare's quality programs. The Commission believes that the Medicare program should take into account, as necessary, differences in a provider's patient population, including social risk factors. However, because adjusting measure results for these factors can mask disparities in clinical performance, Medicare should account for social risk factors by adjusting payment through peer grouping. Medicare should also target technical assistance resources to low-performing providers. Medicare should support research and data collection to reduce measurement bias, including, for example, the effects of social risk factors.

In principle, Medicare quality programs should reward providers based on clear, absolute, and prospectively set performance targets. The Commission encourages CMS to score all SNFs—including low-volume facilities— in the VBP on attainment only.

The Commission supports a VBP design that includes as many providers as possible so that as many providers as possible are held accountable for the care they provide. As discussed above, the Commission understands that low-volume providers present a particular challenge for accurately measuring performance. To expand the number of low-volume providers in the VBP program, the Commission supports calculating their performance scores using two years of data. So that low-volume providers are not unduly weighted by their less-current performance, CMS could consider giving more weight to the most recent performance year.

Regarding assigning a score to low-volume SNFs, we propose a third option, where SNFs with fewer than 25 cases would lose the 2 percent withhold in that program year. As described in the March 2018 report to the Congress, this is consistent with the Commission's approach to clinician quality payments in a proposed voluntary value program, in which payment reductions for clinicians who do not participate would be used to finance payment increases for high-performing groups. This policy would encourage low-volume SNFs to increase their Medicare case sizes so that Medicare can adequately measure the quality of their care, hold all SNFs accountable for the care they provide, and drive quality improvement.

Revisions to the case-mix system

CMS proposes to establish a case-mix classification system with six components: physical therapy (PT) services, occupational therapy (OT) services, speech-language pathology services, nontherapy ancillary (NTA) services, nursing care, and a non–case-mix component (room and board). Three of the daily payments (for PT, OT, and NTA services) will be discounted for care furnished later in a stay to reflect the declining costs of these services. CMS asked stakeholders to comment on whether the new case-mix classification system should be implemented to be budget neutral to the current level of spending.

Comment

The Commission is pleased that this year's proposed rule includes a redesign of the case-mix classification system and applauds CMS's efforts to simplify and refine the design it proposed last year. This year's proposed design and the estimated impacts are consistent with the Commission's own proposal for the SNF PPS and the unified PAC PPS. The proposed case-mix system would base payments on patient characteristics rather than the amount of therapy furnished to beneficiaries. The proposal would also increase the equity of payments across different types of patients so that providers would have less incentive to selectively admit patients with certain conditions and avoid others.

The Commission began discussing needed reforms to the SNF PPS in its June 2007 report and the following year recommended a design to base payments on patient characteristics and to better target payments for nontherapy ancillary services (such as drugs). Each year since its initial recommendation, the Commission has repeated the need to correct many of the well-established shortcomings of the current payment system. These corrections will better target payments for medically complex patients, including patients who require expensive drugs, and make it easier to place these patients at discharge from the hospital.

The Commission is disappointed that CMS plans to delay implementing the proposed changes until fiscal year 2020. Such a delay seems unnecessary given that the design is similar to the design proposed last year, which was developed with the assistance of numerous technical expert panels and accompanied by extensive supportive documentation. Providers should already be well aware of the key design features of the proposal. The postponement will delay the much-needed redistribution of payments away from therapy-driven care and toward medically complex care. Further, because FFS rates form the basis of Medicare Advantage benchmarks and payment for a variety of the alternative payment models, the delay affects payments under these other programs as well those under FFS.

The Commission supports the implementation of the redesigned SNF case-mix system even as it urges the Congress to move as quickly as possible toward a unified PAC PPS. In 2017, the Commission recommended to the Congress that all post-acute care providers be paid under a unified PAC PPS. A PAC PPS would use readily available data to pay for a PAC stay based on the patient's characteristics, not the site of service. Such a system would redistribute payments away from patients who received therapy services that do not appear to be related to the beneficiary's care needs and toward beneficiaries who are medically complex. By narrowing the differences in payments relative to the costs of care, providers would have less incentive to selectively admit certain types of patients and avoid others. This year, the Commission recommended that the Congress, prior to the implementation of a PAC PPS, direct the Secretary to blend setting-specific payments with payments established under a unified PAC PPS beginning in fiscal year 2019. Such blending would begin to redistribute payments consistent with the proposed revisions to the SNF case-mix classification system.

Regarding the budget neutrality of implementing the revised case-mix system, the Commission believes the level of program payments for SNF care is too high relative to the cost to treat beneficiaries. The Commission has variously recommended payment freezes and payment reductions each year over the past decade. Most recently, it recommended to the Congress that payments not be updated for two years while a redesigned payment system is implemented. Then, the Secretary should evaluate the need to make any adjustment to the level of payments to align payments with the cost of care.

CMS's estimates of the impacts of the new case-mix classification system indicate there will be considerable redistribution in payments across different types of patients and providers. This year, the Commission recommended to the Congress that the level of payments remain the same for two years (with no update) while the new payment system is implemented to give providers

time to adjust their practices. At that point, comparing aggregate costs to aggregate payments will indicate the need to adjust the level of payments and the magnitude of any adjustment. While the redesign will narrow disparities in providers' financial performance that result from differing mixes of patients, it would not—and should not—address the disparities that result from providers' inefficiencies. Given the large differences in cost per day (after adjusting for difference in case-mix and wages), it is likely that disparities in financial performance will continue to exist. The level of payments should be evaluated in aggregate (for the industry) rather than focusing on a subset of providers.

Changes to the patient assessment and therapy requirements

CMS proposes to change the schedule of patient assessments so that each patient is assessed at admission (the 5-day assessment), at discharge, and if there is a change in a patient's condition (an interim payment assessment). CMS also proposes to limit the mix of therapy modalities so that group and concurrent therapy combined cannot exceed 25 percent of the total therapy minutes by discipline (physical therapy, occupational therapy, and speech-language pathology services). To enforce this provision, CMS proposes to issue "non-fatal warning edits" when the patient assessment indicates that the group and concurrent therapy minutes exceed 25 percent of the total minutes for a discipline.

Comment

The Commission supports reducing the number of patient assessments that providers will be required to submit, which will lessen the time required to complete assessments and decrease the administrative burden for providers. The Commission agrees with CMS's proposal to use the portion of the patient assessment tool (section GG) that aligns these measures across the PAC settings. By using a smaller window during which the patient is assessed (days 1–3), the information collected will be more comparable across patients and PAC providers.

However, because providers could be influenced by the payment implications of their coding, some of the information gathered, while more comparable across patients and settings, may not be meaningful representations of the care needs of patients. Past SNF practices—including furnishing just enough therapy to qualify a patient into a case-mix group and furnishing enough therapy to assign the majority of days into the highest case-mix groups—suggest that providers will likely alter their behavior to maximize payments. Functional status may be especially vulnerable to manipulation. We encourage CMS to test their classification designs for the nursing, physical therapy, and occupational models without patient function to see if designs that use only administratively gathered data are sufficiently accurate. The Commission's work on a unified PAC PPS found that the accuracy of payments did not erode significantly when only administrative information (e.g., claims and enrollment information) was used. Various measures of a patient's comorbidities and severity of illness captured much of the differences in costs across patients.

The Commission supports the combined limit on concurrent and group therapy and the collection of the information to monitor compliance with this requirement. SNFs have consistently demonstrated they are responsive to payment and policy changes. Without this limit on group and concurrent therapy, it is possible that providers would increase the use of these lower cost modalities even though, from clinical and payment perspectives, CMS states that individual therapy should represent the majority of therapy services.

However, the Commission is concerned that the enforcement mechanism is not strong enough. CMS states that as the provision of group and concurrent therapy increases, it is less likely that a patient's individual care needs are being met, which CMS points out is a requirement of coverage. CMS notes that "services furnished to SNF residents may be considered reasonable and necessary insomuch as services are consistent with 'the individual's particular medical needs,'" thereby raising the question of whether excessive group and concurrent therapy represent a basis to deny SNF coverage. Rather than receive a "warning edit" alerting a provider that the therapy provided to a resident has exceeded the group and concurrent threshold, CMS should determine if these conditions violate the terms of coverage and, if they do, should deny payment for the claim.

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission also values the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact James E. Mathews, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman