MEDPAC Medicare Payment Advisory Commission

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May 8, 2020

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

Re: File code CMS-1737-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; Updates to the Value-Based Purchasing Program for Federal Fiscal Year 2021" in the *Federal Register*, vol. 85 no. 73, p. 20914 (April 15, 2020). We appreciate CMS's ongoing efforts to administer and improve the payment system for skilled nursing facilities, particularly given the many competing demands on the agency's staff.

The Commission's comments are organized into two sections: the update for fiscal year 2021 and the revisions to the statistical area delineations used to construct the wage indexes.

Update to the proposed rates under the SNF PPS

The proposed rule increases Medicare's payment rates for skilled nursing facilities (SNFs) by 2.3 percent, as required by law. On net, Medicare's payments to the SNF sector are estimated to increase by $784 million during fiscal year (FY) 2021. CMS requested comments on the impact of the new case-mix classification system (the patient-driven payment groups, or PDPM) on providers or patient care.

Comment

The Commission understands that by law CMS is required to update the SNF prospective payment system (PPS) rates by 2.3 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 2020 report that the Congress eliminate the update to SNF payments for FY 2021. In 2018, the aggregate Medicare margin for freestanding SNFs was 10.3 percent, the 19th consecutive year that this margin has exceeded 10 percent. This

high level of payments relative to the cost to treat beneficiaries indicates that Medicare's current payment rates are more than adequate to accommodate cost growth.

As you are aware, in 2008 the Commission recommended changes to the case-mix system in 2008 and we applaud the agency's hard work to design and implement the new case-mix system. We agree that it is early to assess the impacts of the new case-mix system on providers and beneficiaries, given the lags in data and the effects of the COVID-19 public health emergency. Once the effects of the case-mix system on utilization and costs can be evaluated, we urge CMS to make the adjustments necessary to maintain the overall budget neutrality of the PDPM so that the level of payments does not change. Further, any adjustments must preserve the relative differences across the case-mix groups so that payments for each case-mix group are accurate and do not result in providers preferring to admit certain case types and avoiding others.

Adoption of the Office of Management and Budget's geographic area delineations to establish the wage indexes

The payment rates for each SNF are adjusted to reflect the relative differences in area wage levels using geographic areas (called core-based statistical areas, or CBSAs) delineated by the Office of Management and Budget. Periodically, OMB revises the delineations and CMS adopts them in establishing the wage index values. On September 14, 2018, the OMB published an updated set of delineations that included new CBSAs, the splitting of CBSAs, urban counties that would become rural, and rural counties that would become urban. In previous adoptions of OMB's revised delineations, CMS has included a one-year transition that blended old and new wage index values to avoid large changes to the wage index values.

Consistent with prior actions, this year CMS proposes to adopt the most recent delineations of geographic areas and include a one-year transition. This year, however, CMS proposes to take a different approach to the one-year transition. CMS proposes to limit the reduction to any wage index value to 5 percent, thus mitigating the impact on SNFs whose wage index values will decrease. CMS proposes to allow SNFs whose relative index values would increase to receive the full benefit of the increased wage index value. The adoption of the new wage index values would be done in a budget-neutral manner.

Comment

The Commission supports the adoption of the new delineations of the geographic areas and the use of a one-year transition to ease the impacts of changes to the wage index values. Regarding the limit on decreases to the wage index values, the Commission supports eliminating wage index changes of more than 5 percent in one year. However, the Commission believes the limit should apply to both increases and decreases in the wage index, not just decreases. This way, no provider would have its wage index value increase or decrease by more than 5 percent for FY 2021. Consistent with CMS's proposed approach, the implementation of the revised relative wage index values (where changes are limited to plus or minus 5 percent) should be done in a budget-neutral manner.

The Commission also reiterates its recommendations on wage index reform included in the Commission's 2007 report to the Congress.[1] We recommended that the Congress repeal the existing hospital wage index and instead implement a market-level wage index for use across other prospective payment systems, including certain post-acute care providers. Specifically, our recommended wage index system would:

- use wage data from all employers and industry-specific occupational weights,
- adjust for geographic differences in the ratio of benefits to wages,
- adjust at the county level and smooth large differences between counties, and
- include a transition period to mitigate large changes in wage index values.

The wage index system we proposed would more fully reflect input prices, automatically adjust for occupational mix, reduce circularity, and reduce large differences between adjoining areas compared with the current system. Two research evaluations commissioned by the Secretary concluded that MedPAC's proposed wage index system would be an improvement over Medicare's current hospital wage index system.[2] We understand that eliminating the current wage index system, and the associated apparatus (such as the rural floors and reclassifications), would require Congressional action, but we urge the agency to consider our recommendations and make adjustments to the current system where it has the discretionary authority to do so.

MedPAC 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 MedPAC 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

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[1] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.

[2] Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy. Second edition.* Washington, DC: The National Academies Press.
MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2009. Revision of Medicare wage index. Final report, Part I.
MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2010. Revision of Medicare wage index. Final report, Part II.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/CMS1237065.html.