

May 25, 2016

Andrew Slavitt, Acting 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-1645-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2017, SNF Value-Based Purchasing Program, SNF quality reporting, and SNF payment research; proposed rule. *Federal Register*, Vol. 81, No. 79, p. 22044 (April 25, 2016). 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 four sections: the proposed update, research on the design of a SNF PPS, value-based purchasing, and quality reporting.

Update to the proposed rates under the SNF PPS

The proposed rule increases Medicare's payment rates for skilled nursing facilities (SNF) by 2.1 percent, reflecting a market basket increase of 2.6 percent and a -0.5 percent productivity adjustment, as required by the Patient Protection and Affordable Care Act (PPACA). On net, Medicare's payments to the SNF sector are estimated to increase \$800 million in FY 2017.

Comment

We understand that CMS is required by law to update the SNF prospective payment system (PPS) rates. However, after reviewing many factors—including indicators of beneficiary access, the volume of services, the supply of providers, and access to capital—the Commission determined that Medicare's current level of payments appears more than adequate to accommodate cost growth—the aggregate Medicare margin for freestanding skilled nursing facilities (SNF) in 2014 was 12.5 percent, the fifteenth consecutive year that it exceeded ten percent.

In March 2016, the Commission recommended that the Congress eliminate the market basket update for FY 2017 and FY 2018, and that CMS use this period to revise the SNF prospective payment system. This recommendation reflects the Commission's growing impatience with the lack of movement toward reform in this setting despite the continued lack of fiscal pressure exerted by the SNF PPS on providers. Not waiting for a revised PPS to be implemented, the recommendation would set small rebasing steps in motion to lower Medicare payments while the SNF PPS is revised. In 2019, with a revised PPS in place, the Secretary would evaluate the effects of the reformed PPS and make any addition payment adjustments needed to more closely align payments with costs.

Research on the design of a SNF PPS

The proposed rule discusses the process CMS has underway to consider alternatives to the SNF PPS. CMS has convened two technical expert panels; one to discuss the therapy component of the PPS and a second to discuss the nursing component, including nontherapy ancillary services. In June 2016, CMS plans to convene a third panel to consider the combined recommendations to the two panels, review the analytic work CMS has completed, and outline a potential revised SNF PPS design.

Comment

The Commission appreciates that CMS expanded the original scope of the research project, from evaluating alternative ways to pay for therapy to considering the entire PPS design. However, the Commission is dismayed that, again, the proposed rule neither corrects the well-established shortcomings of the SNF PPS nor indicates a timeline for when reforms will be implemented.

The pace of CMS's progress has frustrated the Commission. Research spanning more than 14 years has identified the PPS design features that result in patient selection, payment-driven patterns of care, and unnecessary program expenditures. Work by MedPAC and the HHS Office of Inspector General have found that payments for rehabilitation therapy continue to exceed the costs of these services, encouraging providers to furnish therapy services that are unrelated to beneficiaries' care needs. Further, payments for nontherapy ancillary services (such as drugs) bear no relationship to the cost of these services. The Commission laid out the foundation for a revised PPS in 2008 and despite CMS's many refinements to the PPS, the accuracy of Medicare's payments has actually deteriorated.

In June 2016, the Commission transmitted a report to the Congress outlining the features of a payment system to span the four post-acute care settings—inpatient rehabilitation facilities (IRF), SNFs, some health agencies (HHA), and long-term care hospitals (LTCH). We found that a unified payment system would establish accurate payments for most clinical patient groups. Like our recommended SNF PPS redesign, a unified PAC PPS would base payments on patients' characteristics, not the amount of therapy provided to them.

Our work confirmed that a reasonably accurate payment system could be designed using administrative data and so the Commission noted that the Secretary could consider moving ahead with a PAC PPS more quickly than anticipated under the timeline indicated in Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014. A revised SNF PPS or a unified PAC PPS would represent a marked improvement over the current design. Therefore, the Commission urges CMS to pick a strategy and move as expeditiously as possible towards much needed payment reform in this setting.

Value-based purchasing for SNFs

The Protecting Access to Medicare Act (PAMA) of 2014 requires the Secretary to implement a value-based purchasing (VBP) program for SNFs beginning in October 1, 2018. The law requires the VBP program to vary Medicare payments for SNF services using one measure, the rate of all-cause, all-condition 30-day readmissions, as specified in the FY 2016 SNF PPS final rule. Further, the Secretary must specify a potentially preventable readmission measure by October 1, 2016 and, as soon as practicable, use this measure to adjust payments (replacing the all-cause, all-condition measure). In assessing SNF performance, the Secretary is required to rank each facility's performance (i.e. on their readmission rates) and consider the higher of a SNF's improvement or attainment. The law requires that the Nursing Home Compare website include: the performance of each SNF, aggregate information on the range of SNF scores, the total number of SNFs receiving incentive payments, and after ranking SNF performance scores from low to high, display these rankings.

Comment

The Commission supports VBP policies as a way to encourage providers to furnish high-value care to Medicare beneficiaries. Although PAMA specifies a single performance measure (a readmission measure), the Commission urges CMS to broaden the scope of the VBP policy to include other post-acute care outcome measures. It is not clear from our reading of the law if CMS has the authority to build out the SNF VBP policy. If it does not, the Commission can play a role in expanding the scope of this policy.

Though the adoption of too many measures could diffuse provider focus, a small number of additional performance measures would signal to providers the other key aspects of care, including: a measure of safe transitions to the next setting or home (such as a readmission rate for the 30 days after discharge from the SNF), a measure of resource use over an episode of care (such as the Medicare spending per beneficiary-post acute care), and a measure of beneficiary functional change. These measures of care are required of all PAC providers, including SNFs, though the implementation dates vary by measure and setting.

In the context of quality reporting, the Commission has supported a measure of potentially preventable readmissions (PPR) during the SNF stay and a measure of PPR covering the 30 days after the patient is discharged. We believe that a VBP should at least include both of these measures at the outset. So that SNFs have a strong incentive to avoid PPRs over the course of the entire episode, we prefer a single measure that combines to form a single "stay plus 30 days post discharge" measure. Expanding the time period covered by the measure would encourage

providers to consider the care of beneficiaries over an episode and begin to align this measure with future payment reforms, which are likely to include some form of episode-based bundled payments.

Regarding the readmission measures required by current law, the Commission supports the adoption of a measure of potentially preventable readmissions (PPR) to replace the all-cause measure but notes both measures (the all-cause and PPR) could be improved. First, both measures include only readmissions that occur within 30 days of discharge from an inpatient acute-care hospital, critical access hospital, or psychiatric hospital. The Commission believes SNFs should be held accountable for every readmission that occurs while the beneficiary is in their care. Because SNF stays often exceed 30 days (about one-third of stays are longer than this), using this definition will relieve SNFs of the responsibility for beneficiaries who have a readmission after the 30 days but who are still patients in the SNF. Further, the current definition could create incentives for SNFs to delay needed hospital care until after the 30th day to avoid including the readmission in its performance measure. Another problem with the measure definition is that for stays that are shorter than 30 days, the current definition includes a mix of days while the patient is in the SNF and days after discharge from the SNF. For short stays, the days after discharge from the SNF will also be counted in the proposed 30-day post measure of readmissions (discussed below), thus overlapping the two readmission measures.

The Commission believes that a PPR measure should replace the all-cause measure as soon as possible because the preventable measure holds providers accountable for conditions that generally can be managed in SNFs (and does not hold them accountable for conditions that generally cannot be managed by them or were planned). Given the timelines laid out in the proposed rule, it appears that a PPR measure could be implemented in October 2019 (FY 2020). The PPR measure specification will be finalized by October 2016. Then, CMS can publish performance standards (based on calendar year 2016 data) by November 2017 so providers understand their targets for the following calendar year. Providers would then have calendar year 2018 to improve their PPR rates before that data is scored as part of the VBP beginning October 2019.

Another concern is a part of the risk adjustment method used to account for differences among patients in their risk of readmission. CMS proposes to include the number of hospitalizations during the previous year as a factor in the risk-adjustment. While we agree that the rates need to be adjusted for differences in patients' complexity and risk of readmission, we disagree with the inclusion of this factor in the risk adjustment because it could result in adjusting a facility's rate for the potentially preventable readmissions that occurred during the previous year. If a facility did a poor job preventing preventable readmissions in the prior year, its patients would have had more hospitalizations, and yet the facility would have a lower readmission target rate.

Quality and resource use reporting

The IMPACT Act of 2014 requires the implementation of several quality and resource use measures that are standardized and interoperable across post-acute care settings including measures of: function and cognition, skin integrity, medication reconciliation, incidence of major falls, the transfer of health information and care preferences, readmissions, discharge to

community, and resource use. The SNF proposed rule discusses four measures for adoption in the SNF quality reporting program: drug regimen review with follow up, the resource use measure (Medicare spending per beneficiary—Post Acute Care SNF), discharge to community, and potentially preventable readmissions within 30 days after discharge from the SNF. CMS invited comments on how socioeconomic (SES) factors should be used in the resource use and quality measures.

Comment

Because the goal of cross-cutting measures is to gauge and compare care provided across PAC settings, it is critical that each measure use uniform definitions, specifications (such as inclusions and exclusions), and risk-adjustment methods. Otherwise, differences in rates across settings could reflect differences in the way the rates were constructed rather than underlying differences in the quality of care. Our work on the design of a unified PAC payment system and the work of others indicate considerable overlap in where beneficiaries are treated for similar PAC needs. These results indicate it is imperative that quality and resource use measures are directly comparable across settings so that Medicare can evaluate the value of its purchases and beneficiaries can make informed choices about where to seek care. Separate measures will continue to evaluate each PAC setting in isolation rather than support cross-setting comparisons of PAC providers. We emphasize this principle in our discussion of the MSPB measure, but note that the principle applies to all four of the IMPACT measures discussed here.

The Commission recognizes that socio-economic status (SES) factors can play a role in the outcomes for quality and resource use measures. One way to consider SES factors is to include them in the risk adjustment method. The Commission does not support this approach because it results in adjusted rates (or spending) that hide the actual disparities in care, and could reduce pressure on providers to improve care for the poor. The Commission believes that a better way to address any differences in outcomes is to compare rates (or spending) that have not been adjusted for SES across “peer” providers that have similar shares of, for example, low-income, beneficiaries. This way, the outcome rates remain intact but the comparisons are “fair” because providers are compared with other providers with similar shares of low-income beneficiaries.

To promote transparency for beneficiaries and competition across providers, the Commission supports the public reporting of the cross-cutting quality measures. CMS should move towards reporting the cross-cutting quality measures for all providers in each setting—for example, in Nursing Home Compare or its successor for SNFs.

Drug regimen review conducted with follow-up for identified issues—CMS is proposing to adopt a drug regimen review measure that reports the percentage of resident stays in which a drug regimen review was conducted at the time of admission and timely follow-up with a physician each time potentially clinically significant medication issues were identified. The purpose of the measure is to encourage PAC providers to perform a review of all medications a patient uses to identify and resolve any potential adverse effects and drug reactions (including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy).

Comment

The Commission supports CMS's proposed medication reconciliation measure. The medication and reconciliation and follow-up process can help reduce medication errors that are especially common among patients who have multiple health care providers and multiple comorbidities. In addition to the measure proposed, MedPAC encourages CMS to assess whether PAC providers conduct medication reconciliation when discharging their patients. For example, CMS could also measure whether a PAC provider sends discharge medication lists to either the next PAC provider or, if being discharged home, to the patient's primary care provider.

Medicare spending per beneficiary (MSPB)–Post-acute care SNF—CMS proposes a measure of resource use that includes the average risk-adjusted total Medicare spending per beneficiary during the SNF stay and the 30 days after discharge from the SNF. By holding SNFs accountable for resource use over episodes of care, the measure will increase a provider's responsibility for care furnished during their own "watch," a safe transition to the next setting or home, and for care during the next 30 days. CMS is developing separate MSPB measures for each of the four PAC settings; the proposed rule describes the MSPB–PAC SNF measure.

Comment

The Commission supports the adoption of a resource use measure that promotes providers' responsibility for episodes of care. By reporting provider's performance regarding resource use during their patients' stays plus 30 days after discharge, the measure will ready providers for broader payment reforms that extend providers' responsibility for episodes of care, such as bundled payments. However, the Commission does not support the development of setting-specific measures. We believe a uniformly defined resource use measure for all four PAC settings, rather than separate measures for each PAC setting (such as the MSPB–PAC SNF), will better meet the intent of the IMPACT Act and enable comparisons across PAC settings. Under a single measure, the episode definitions, service inclusions/exclusions, and risk adjustment methods would be the same across all PAC settings.

Until there is a uniform PAC PPS and payment differences between settings are eliminated, the Commission appreciates that a single measure would, without other adjustment, consistently advantage lower-cost settings and disadvantage higher-cost settings due to the large spending differences associated with the initial PAC stay across the settings. Therefore, to assess providers' performance in the near term, CMS should use a single measure and compare providers within each setting (i.e. a SNF's spending would be compared with other SNFs' spending, an IRF's spending would be compared with other IRFs, et cetera). In the future, comparisons of the single measure could be made across all PAC settings.

Discharge to community—This measure is a risk-adjusted rate of FFS beneficiaries who are discharged to the community following a PAC stay and do not have unplanned hospital readmissions during the 31 days following discharge to the community. CMS proposes to gather the discharge status from the PAC claim.

Comment

The Commission supports this measure; it has used a similar measure to track the quality of SNFs and IRFs for several years. However, the Commission urges CMS to confirm discharge status by matching claims between the discharging PAC provider and any subsequent institutional provider (a hospital, IRF, SNF, or LTCH). CMS evaluated the accuracy of the discharge status field on the PAC claim by examining the agreement between the “discharge status” on the PAC claim and the presence of a subsequent acute hospital claim, and the agreement between the PAC claim and the SNF patient assessment. The agreement between the PAC claim and hospital claim was high (about 90 percent) but the agreement between PAC claims (for example, an IRF claim indicated the beneficiary was discharged to a SNF and there was a subsequent SNF claim) was not reported. And although the reporting of discharge status between a PAC claim and the patient assessment may be consistent, this agreement does not confirm the patient was discharged to the community. To ensure that rates reflect actual performance, “discharged to the community” should be confirmed with the absence of a subsequent claim to a hospital, an inpatient rehabilitation facility, SNF, or a long-term care hospital.

Potentially preventable 30-day post-discharge readmission—This measure assesses a facility’s risk-adjusted rate of unplanned, potentially preventable hospital readmissions for Medicare FFS beneficiaries in the 30 days after discharge from the SNF.

Comment

The Commission supports this measure, believing that SNFs should be held accountable for safe transitions to the next setting (including home). MedPAC has tracked a post-discharge readmission measure over multiple years for SNFs and IRFs. As noted above, the measure definition and risk adjustment should be identical across the four PAC settings so the post-discharge rates can be meaningfully compared.

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 Mark E. Miller, MedPAC’s Executive Director at (202) 220-3700.

Sincerely,



Francis J. Crosson, MD
Chairman