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June 14, 2019

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-1718-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 Quality Reporting program and Value-Based Purchasing Program for Federal Fiscal Year 2020" in the *Federal Register*, vol. 84, no. 80, p. 17620 (April 25, 2019). 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 four sections: the update for fiscal year 2020, the wage index, revisions to the discharge-to-community measure, and changes to the definition of group therapy.

Update to the proposed rates under the SNF PPS

The proposed rule increases Medicare's payment rates for skilled nursing facilities (SNFs) by 2.5 percent, as required by law. On net, Medicare's payments to the SNF sector are estimated to increase by \$887 million during fiscal year (FY) 2020. The payment update for providers failing to submit data required for the quality reporting program (QRP) will be reduced by 2 percentage points.

Comment

The Commission understands that by law CMS is required to update the SNF prospective payment system (PPS) rates by 2.5 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 2019 report that the Congress eliminate the update to SNF payments for FY 2020. In 2017, the aggregate Medicare margin for freestanding

SNFs was 11.2 percent, the 18th 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.

SNF wage index

Historically, CMS has calculated the SNF PPS wage index using unadjusted wage index values (pre-reclassification, unadjusted for occupational mix and the rural floor) from acute care hospitals. In response to stakeholder comments on certain aspects of the wage index and its impact on payments, the FY 2020 proposed rule requested feedback regarding the wage index used to adjust SNF payments and suggestions for possible updates and improvements to the geographic adjustment of payments.

Comment

In response to CMS's request for comments on and improvements to the current wage adjustments made to SNF payments, we wish to reiterate our 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.

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 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.

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. and 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>

Revisions to the discharge-to-community quality measure

As part of the SNF quality reporting program (QRP), CMS calculates a risk-adjusted rate of FFS beneficiaries discharged to the community from a SNF stay who do not have a subsequent hospital readmission and who remain alive during the following 31 days. It is a measure of whether a provider keeps its patients and—in the case of nursing facilities, its residents—out of the hospital and alive after returning from a preceding hospitalization. CMS proposes to exclude patients who were nursing facility residents before a SNF stay from the measure calculation because they are not expected to return to the community following their stay.

Comment

The Commission maintains that Medicare quality measures should be patient oriented, encourage coordination across providers and time, and promote improvement in the delivery system. Medicare quality programs should include population-based outcome measures that are not unduly burdensome for providers. For example, measures that can be calculated by CMS using claims data represent a low level of provider burden. Therefore, the Commission supports the inclusion of a discharge-to-community measure in the QRP. However, the Commission does not support CMS's proposal to remove nursing home residents from the measure sample because providers should be held accountable for the quality of care they provide for as much of their Medicare patient population as feasible. Rather, the Commission supports the expansion of the definition of "return to the community" to include nursing home residents returning to their residence—that is, the nursing home where they live.

Most, but not all, nursing homes furnish long-term care to residents, most of whom live there, and skilled nursing care to patients who may or may not live there. Long-term care makes up the majority of days in the typical nursing home, and most nursing home residents (who are primarily Medicare beneficiaries) use long-term care. When these residents require acute hospital care, the vast majority return from the hospital to the nursing facility for their skilled nursing care needs and then remain there for their long-term care. These beneficiaries are, effectively, returning "home" to their "community."

Nursing homes vary considerably in their mix of long-term care and skilled care. The patients, their comorbidities, and the services furnished during long-term care and skilled care also differ considerably. Some quality measures are most relevant for short-stay patients, while others are more relevant for long-stay patients. Some measures, such as the risk of readmissions and death, are key adverse events for both populations so a measure of safe discharge "home" (i.e., without readmission or death) is relevant to both patient groups.

Excluding nursing home residents from the measure would essentially hold nursing homes harmless for these adverse events (readmissions and death) for their long-term care residents. Given the wide variation across providers in their long- and short-stay mixes of patients, the proposed revision would affect providers differently, excluding a large share of residents from the calculation for nursing homes that provide mostly long-term care and excluding a small share

from the calculation for providers that provide mostly skilled care. A nursing home that treats mostly long-term care residents could have most, if not all, of its residents excluded from the measure. Beneficiaries or their families who consider these rates in selecting a provider may not know that the measure would reflect only a small share of the prospective provider's business.

Changes to the definition of group therapy

CMS proposes to change the definition of group therapy and the documentation requirements for the use of group therapy. Currently, group therapy is defined as a physical therapist or therapy assistant treating four patients engaged in the same or similar activity at the same time. During a Medicare Part A–covered stay, group and concurrent therapy minutes together cannot make up more than 25 percent of the therapy furnished to a beneficiary, thus leaving intact the requirement that individual therapy is the dominant modality.³ CMS proposes to allow a therapist or therapy assistant to treat between two and six patients in group therapy. Therapists would be required to document why group therapy is the most appropriate therapy modality to meet the beneficiary's needs.

Comment

The Commission supports the expanded flexibility that the proposed definition of group therapy encompasses but does not agree with the proposed increase to the size of the group that would be allowed. The additional flexibility would respect the capabilities and clinical judgment of therapists to determine the appropriateness of group therapy to best meet the needs of each beneficiary. However, the Commission is concerned that skilled nursing facilities (SNFs) have shown they are highly responsive to financial incentives.⁴ When revisions to the SNF PPS are implemented in FY 2020, it is likely that financial incentives will, again, influence provider practices so that the shares of patients receiving group therapy and the size of the group will increase, both of which would lower a provider's costs. Requiring documentation supporting the provision of group therapy and the size of the group may not be a sufficient deterrent for the inappropriate use of group therapy—in the same way that program requirements for medical necessity did not prevent the large increase in the provision of therapy so that more days were assigned to the highest case-mix groups.

To constrain the use of group therapy, the Commission does not support increasing the maximum number of patients who can be treated at the same time. However, to give providers more flexibility regarding the size of the group, providers could be allowed to treat between two and four patients engaged in the same or similar activities at the same time. Capping the group size at four patients while allowing some flexibility strikes a balance between limiting the use of

³ *Concurrent therapy* is therapy provided by a physical therapist or therapy assistant treating two patients engaged in *different* activities at the same time.

⁴ Changes in the mix of days assigned to case-mix groups and the use of group and concurrent therapy are examples of provider responses to the financial incentives inherent in the SNF PPS and the accompanying rules regarding therapy modalities (Medicare Payment Advisory Commission, 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.).

group therapy while respecting the clinical judgment of providers. Once a uniform PAC PPS is implemented and the mix of patients across PAC providers becomes more uniform, these requirements can be revisited.

In revising the requirements regarding the size of the group, CMS discussed the group therapy requirements for outpatient settings and inpatient rehabilitation facilities (IRFs). While the Commission has long noted the overlap of many patients treated in SNFs and IRFs, beneficiaries admitted to IRFs must be able to tolerate intensive therapy and, therefore, are often younger and have lower risk scores and fewer comorbidities. Beneficiaries who can receive therapy on an outpatient basis are unlikely to be similar to the typical beneficiary treated in a SNF. Therefore, the group therapy requirements for outpatient settings and IRFs may not be appropriate for many SNF patients.

The numerous substantial changes to the SNF PPS that will be implemented in October 2019 warrant careful monitoring of provider practice patterns, including the use group therapy. If inappropriate provider responses are detected, CMS will need to take actions that clearly signal to the industry that any practices that jeopardize beneficiary safety and quality of care will not be tolerated.

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,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive style.

Francis J. Crosson, M.D.
Chairman