MEDPAC Medicare Payment Advisory Commission

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June 25, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 310-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-1534-P

Dear Mr. Weems:

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 2009,* Federal Register, Vol. 73, No. 89, p. 25918 (May 7, 2008). We appreciate your staff's ongoing efforts to administer and improve the payment system for skilled nursing facilities, particularly given the agency's competing demands.

As required by law, the proposed rule updates payments by a factor equal to the full market basket percentage increase (3.1 percent). After recalibrating two payment adjustments first implemented in 2006 (the parity and the nontherapy ancillary adjustments), the proposed rule would, on net, lower aggregate payments by 0.3 percent. We note that after reviewing many factors—including indicators of beneficiary access, the volume of services, the supply of providers, and access to capital—Medicare's payments appear more than adequate. In 2006, the aggregate Medicare margin for freestanding SNFs was 13.1 percent, the sixth year in a row it exceeded ten percent. The Commission concluded that SNF payments are more than adequate to accommodate cost growth and in March 2008 recommended to the Congress that the industry receive no update.

MedPAC is concerned that the proposed rule does not correct the two key shortcomings of the SNF PPS: payments are not targeted for nontherapy ancillary (NTA) services and a large portion of the daily payment is based on the amount of therapy provided or expected to be provided. As a result, payments continue to be too high for rehabilitation patients and too low for medically complex patients, making some beneficiaries more difficult to place in SNFs than others.

The proposed rule does not change how Medicare pays for NTA services under the current PPS. Payments for these services remain tied to nursing time, yet NTA costs do not necessarily vary with nursing time and are much more variable. The refinements implemented in 2006—the

addition of the nine case mix groups and the across-the-board increases in nursing payments for NTA services in 2006—only marginally increased the ability of the PPS to explain differences in NTA costs per day. The proposed recalibrations of the parity and NTA adjusters may exacerbate the incentive to avoid patients who require expensive NTA services. The recalibrations would result in larger reductions in nursing payments and total payments for patients in the extensive services, clinically complex, and special care RUGs than for patients in the rehabilitation and rehabilitation plus extensive services RUGs.

The proposed rule does not correct the incentive to furnish therapy services for financial, rather than clinical reasons. The share of days grouped into the highest rehabilitation case-mix groups continues to increase. Between 2005 and 2006, the share of patients grouped into the ultra high and very high rehabilitation case-mix groups grew 7 percentage points, making up 59 percent of the rehabilitation-only days in 2006. To reverse this steady shift from lower to higher rehabilitation RUGs, the PPS needs to base payments on patient care needs, not service provision.

Our most recent work with researchers at the Urban Institute developed an alternative design for a PPS that would better target payments to stays with high NTA costs, and more accurately calibrate therapy payments to therapy costs. Our work found that NTA and therapy costs can be predicted more accurately using patient and stay characteristics than current policy and would not encourage therapy provision to boost payments. Based on this work, in June the Commission recommended to the Congress that the SNF PPS be redesigned to establish a separate component to pay for NTA services and replace the current therapy component with one that bases payments on patient care needs rather than on the services furnished. We also recommended that an outlier policy for ancillary services be added to the PPS as a way to offer SNFs, and the patients they treat, some financial protection from stays with exceptionally high ancillary costs.

The proposed rule discusses the agency's timetable for making further changes to the SNF PPS, including revisions to the case-mix system. In FY 2010, CMS tentatively plans to update the staff times used to establish the nursing and therapy component weights and make structural revisions to the classification system. We urge CMS to use this opportunity to consider the Commission's recommended alternative design for the PPS that would improve payment accuracy and to correct the current incentives to furnish therapy for financial rather than clinical reasons.

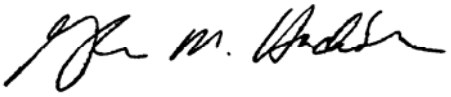
The proposed rule discusses CMS's plans for revising the Minimum Data Set, the SNF patient assessment tool. The Commission would like to reemphasize the importance of requiring that assessments be completed at admission and discharge so that changes in a patient's condition can be accurately measured and outcomes assessed. Until this information is gathered, it will be impossible to tie Medicare's payments to patient outcomes. In addition, the MDS should be revised to gather information about services furnished during the SNF stay so that payments to SNFs are not based on services provided during the preceding hospital stay.

The proposed rule seeks comments about the applicability of healthcare-associated conditions for value-based purchasing in SNFs. In March 2008, the Commission recommended that CMS establish a pay-for-performance program and discussed the inclusion of potentially avoidable rehospitalizations in a starter measure set. A pay-for-performance program that uses

rehospitalizations as a measure is one step in the path of holding multiple providers accountable for reducing the number of unnecessary rehospitalizations.

If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/cc/wc