MEDPAC Medicare Payment Advisory Commission

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July 8, 2005

Mark McClellan, 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-1282-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to comment on CMS's proposed rule entitled *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006*, Federal Register/ Vol. 70, No. 96 (May 19, 2005), which updates the payment rates for the skilled nursing facility (SNF) prospective payment system (PPS) and proposes refinements to the SNF case-mix classification system. After a general overview, detailed comments on specific elements of the proposed refinement appear under the captions that correspond to the relevant section in the proposed rule, where applicable.

Refinement overview

The SNF prospective payment system's distribution of payments results in inadequate payment for nontherapy ancillary (NTA) services, such as prescription drugs and IV therapy. This issue has been a matter of concern for the Congress, MedPAC, GAO, CMS, industry stakeholders, and researchers since the early years of the SNF prospective payment system. Inadequate payment distribution for NTA services is a function of the design of the payment system—while the NTA costs were part of the total costs used to develop Medicare's SNF base payment rates, NTA costs were not used to develop the weights that adjust the base payment rates according to patients' resource use. As a result, the payment system does not distribute payments for NTAs according to variation in expected NTA costs across different patient types.

MedPAC is also concerned about the incentives regarding the provision of therapy under the current payment system. The current system has two incentives related to the provision of therapy. The first is for SNFs to provide additional therapy to achieve higher payment even though the patient may not benefit from additional therapy. The second is to provide the fewest number of minutes of therapy in the highest achievable payment group.

We conclude that the proposed refinement is inadequate because it does not directly target payment for nontherapy ancillary services and makes no change to the policy of basing a substantial portion of the SNF per diem payment on the amount of therapy provided. Other reform options that demonstrated improved explanation of NTA and total cost variance are available to CMS. We request that research conducted by the Urban Institute and others on the performance of various RUG refinement options as well as alternative case-mix systems, such as APR-DRGs, be made available as soon as possible to enable a broader policy discussion on the merits of the current and alternative case-mix systems.

Case-Mix Adjustment and Other Clinical Issues

NTA payment

CMS proposes to retain the RUG-based structure of the payment system and add nine new extensive services plus rehabilitation payment groups. These new groups would become the highest payment categories. CMS also proposes to increase the value of the nursing weights of the new and existing payment groups "by calculating a percentage increase that would increase aggregate payments." CMS describes these refinements as a "means of achieving more appropriate payment for these services without the potential drawbacks of our earlier proposal in terms of complexity and addressing variability in utilization." We are concerned that this refinement does not help achieve this goal of more appropriate payment because the payment system does not have a mechanism for targeting payment for nontherapy ancillary services.

The proposed refinement would increase payments for one group of patients that has among the highest NTA costs on average—patients who qualify for extensive services plus rehabilitation. CMS uses the higher NTA costs of extensive services plus rehabilitation patients, relative to patients in rehabilitation alone groups, to justify, in part, creating separate groups for these patients. But at the same time, the patient group with the highest average NTA costs would have its payment rate reduced under the proposed refinement and loss of the add-ons. Payment for extensive services patients, who had higher average NTA costs than those who classify into all other categories, is actually lower, relative to both the previous year and relative to other payment groups. The following example shows that while the payment for one of the new extensive services plus rehabilitation groups increases 3.5 percent under the new payment system, the per diem payment for a patient in an extensive services group is reduced by 11.8 percent.

Per diem payment changes for three RUGs using revised proposed urban rates

	RUG-44 (FY 05) + add on	RUG-53 (Jan. 06)	Difference RUG-44 and RUG-53
High rehabilitation (RHC)	$352.49	$342.09	-3.0%
High rehabilitation +extensive services (RHC/RHX)	$352.49	$364.74	3.5%
Extensive services (SE3)	$369.41	$325.67	-11.8%

Source: "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update—Notice," Federal Register, Vol. 69, No. 146 , July 30, 2004 and "Preliminary analysis of RUG-53 case-mix adjusted federal rates and associated indexes—urban, updated for 2001 data," http://www.cms.hhs.gov/providers/snfpps/PrelimAna-cma-urban.pdf.

CMS is increasing the nursing weights of all payment groups because of variability in NTA costs within and across groups; but uniformly increasing payments to all groups is not a proxy for better targeting NTA payments. CMS asserts that an alternative approach—using a separate index (as proposed in the 2000 rule and further developed in Urban's research) based on conditions that predict NTA costs to determine payment for NTA services—would create excessive complexity by increasing the number of payment groups. We find this argument unpersuasive. Such an index does not have to create additional groups; it can be considered a modifier to an existing system. In addition, complexity should be weighed against improving the targeting of payment in the skilled nursing facility PPS. If CMS releases it, the Urban Institute's research could facilitate a more complete discussion of the merits and feasibility of various index approaches for NTA payment. Finally, we can find no analytic basis for CMS's decision to determine the size of the increase in the nursing weights using the size of the inpatient rehabilitation outlier pool.

Therapy payment

With respect to our second major concern with the SNF PPS—payment based on the amount of therapy provided or estimated to be provided—we find that the proposed refinement does not correct incentives to provide therapy to maximize payment. We recognize that this problem likely requires fundamental changes to the payment system and that prospectively determining the appropriate amount of therapy is difficult.

That said, we have concerns about the therapy weights used to adjust payments under the proposed refinements. More than a month after publishing the proposed rule, CMS acknowledged errors in the therapy weights; they then published recalculated weights

that also use newer data on their website. To recalculate these weights, CMS made adjustments, including an adjustment to the therapy and nursing weights to make aggregate payments equal under the proposed new and old payment systems. We also have questions about the accuracy of the recalculated weights because the method for recalculating the therapy weights appears inconsistent with the previously used method. We are concerned that these issues have created confusion in the policy community and among industry stakeholders. CMS should provide correct weights and a complete, transparent explanation of all their methods for deriving the weights in time for public review and comment.

As a final note on the therapy weights, we would like to point out the heterogeneity in therapy provided to the highest newly created payment groups, RUX and RUL. Because of CMS's method for developing the therapy weights, these two groups have the same therapy weight applied to derive their therapy payments, despite having a more than four-fold difference in the average minutes of therapy provided per day.

Proposed Refinement to the Case-mix Classification System

CMS asked for comments on issues related to the Minimum Data Set (MDS) instructions. Our comments on these specific issues follow.

Elimination of the look back instruction in the MDS

Currently, SNFs are instructed to look back a specified number of days when answering questions on the MDS about patients' conditions and services or treatments that a patient receives. As a result of this look-back, the information on the MDS may refer to conditions that were present and treatments received during the prior hospital stay. This proposed change would restrict the data collected on the MDS to services furnished during the SNF stay. Although the rule does not mention this, research by the Urban Institute found that conditions and treatments that occurred only during the SNF stay better predicted per diem SNF costs than those same conditions combined with treatment provided during the preceding hospital stay. For this reason, we believe that eliminating the look-back period for payment purposes is appropriate.

Accurate patient classification is especially important in light of the addition of the nine new extensive services plus rehabilitation RUGs because the look-back period is currently used to determine whether a patient qualifies for the extensive service category. Eliminating the look-back period has implications for estimating the number of SNF patients that qualify for the proposed new payment groups. CMS should clarify whether their estimation of the number of days on the new payment groups is based on classification with or without the look back.

Elimination of the projection of anticipated therapy on the 5-day PPS assessment

Currently, on the first MDS assessment a patient can be categorized into a high, medium, or low rehabilitation group using an estimate of the amount of therapy that will be provided, rather than the actual amount provided, during the first two weeks. For all subsequent assessments, the beneficiary must have already received the minimum amount of therapy that defines a group in order to be categorized in that group. GAO found that half of the patients initially categorized into high or medium groups did not actually receive the minimum minutes to be classified in these groups. Eliminating the use of estimated therapy minutes to classify patients would likely reduce the mismatch between estimated and actually provided therapy.

SNF quality measurement

The Commission has recommended that the Secretary require assessment of SNF patients' functional status at admission and discharge. In addition, recently introduced legislation also calls for the collection of these data. The Secretary has the authority to act on MedPAC's recommendation, which could be implemented with little provider burden and is critical to facilitating assessment of patients in the SNF setting. Without an assessment at discharge it is currently impossible to know to what extent SNF patients improved during their stay. CMS should take this vital step towards quality measurement in the final rule.

Coordinated payment and delivery of post-acute services

CMS expressed the need to investigate a more coordinated approach to payment and delivery of post-acute services that focuses on the overall post-acute episode. We are pleased that CMS is thinking about this topic. As we testified before the U. S. House Ways & Means Subcommittee on Health in June, this is an agenda item for MedPAC as well and we look forward to working with CMS on this complex and important issue.

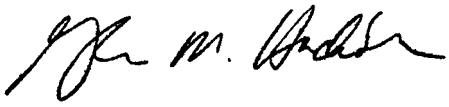
<u>Proposed revisions to the SNF PPS Labor Market Areas</u>

CMS is proposing to define urban areas as metropolitan statistical areas or metropolitan divisions; micropolitan and outside CBSA counties would be considered rural. This proposal is consistent with the labor market areas that were adopted under the IPPS on October 1, 2004. However, unlike inpatient hospitals, SNFs going to a lower wage index under the new geographic definitions will not be afforded a transition period in which their wage index would be a blend of old and new.

CMS is proposing to adopt the new labor market designations effective January 1, 2006. As we commented on the IPPS proposed rule, facilities should be treated equitably, and large payment changes should be phased-in over time in a budget-neutral manner. The payment effects of the new labor market designations should be phased-in in the same manner as they were for inpatient hospitals.

MedPAC appreciates your consideration of our comments. If you have any questions or need clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director at (202) 220-3700.

Sincerely,



Glenn M. Hackbarth
Chairman

GMH/kl/w