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July 3, 2003

Thomas Scully, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
Room 443-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1469-P and CMS-1469-P2

Dear Mr. Scully:

The Medicare Payment Advisory Commission (MedPAC) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' proposed rule entitled *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Update*, Federal Register Vol. 68 No. 95, pages 26757-26783 (May 16, 2003), and the supplement with the same title in the Federal Register Vol. 68 No. 111, pages 34767-34773 (June 10, 2003). We appreciate your staff's ongoing efforts to administer and improve the skilled nursing facility (SNF) prospective payment system, particularly considering the competing demands on the agency.

Our comments focus on five specific areas: the proposed update to the fiscal year 2004 SNF payment rates, the proposed market basket forecast error correction, the distribution of resources in the SNF payment system, the need to monitor beneficiaries' access to SNF services, and the need to promote quality of care in SNFs.

Update to the fiscal year 2004 payment rates

The Commission recommended no update to SNF payment rates for fiscal year 2004. As we indicated in our March 2003 Report to the Congress, our analysis of Medicare cost report data finds that aggregate Medicare payments for SNF services in fiscal year 2003 are more than adequate with the overall Medicare margin for all SNFs at 5 percent and the Medicare margin for freestanding SNFs (90 percent of all SNFs) at 11 percent.[1]

[1] Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy. Washington (DC), MedPAC. March 2003. The Medicare margin is calculated as revenue minus costs, divided by revenue.

Continued entry of for-profit freestanding providers, increases in the volume of SNF services, and continued access to services for most Medicare beneficiaries suggest that payments are adequate. Furthermore, we continue to see a decline in costs in freestanding facilities, which does not appear to have resulted in lower quality of care. We expect that SNF costs will continue to decline in fiscal year 2004.

Correction for the market basket forecast error

Because SNF payments appear more than adequate to cover the costs of caring for Medicare SNF patients at this time, the fiscal year 2004 payment rates are not the right vehicle to correct SNF market basket forecast errors that occurred in fiscal years 2000 through 2002. When computing the aggregate Medicare margins for SNFs, MedPAC accounts for differences between the forecasts and the actual changes in the market basket index. After accounting for the underestimate of the market basket in fiscal years 2000 through 2002, we estimate the Medicare margin for freestanding SNFs to be 11 percent for fiscal year 2003. If the forecast error had not occurred (or had been corrected), the fiscal year 2003 aggregate Medicare margin for freestanding SNFs would be substantially higher than 11 percent, all else being equal.

If CMS were to retroactively adjust fiscal year 2003 SNF payments to correct for forecast errors that occurred years ago, the result would be larger Medicare overpayments to SNFs than currently exist. The proposed forecast error correction for 2000 through 2002, combined with the proposed full market basket update, would increase SNF payments for 2004 by a total of 6.16 percent. The magnitude of this increase, especially when added to payment rates that are already more than adequate, lends urgency to the Commission's recommendation that the Congress should eliminate the update to payment rates for freestanding SNF services for fiscal year 2004.

From a purely analytical perspective, retroactively correcting for forecast errors is a good idea *if* the payment system is functioning perfectly in all other respects. However, the SNF prospective payment system currently pays more than the costs of providing care to beneficiaries (as discussed above) and causes payments to be distributed incorrectly within the system (as discussed in MedPAC's March 2003 report). It is inappropriate to make this one correction to the payment system without also addressing other issues that need correcting.

However, if CMS decides to implement an automatic adjustment mechanism to correct for forecast errors in the SNF market basket, we agree with the agency on a number of key design issues. First, it is imperative to apply such an adjustment both when the forecasted percentage change in the market basket is higher than the actual market basket increase, and when it is lower. That is, the adjustment must be uniform, even though this may add to uncertainty about payments from year to year. Second, if CMS decides on correcting the base rate for forecast error, the agency should announce its plans to make this adjustment beginning at a specific time (e.g., 2005) and only make the adjustment from that time forward. Finally, we believe a threshold amount (such as 0.25 percentage points), below which the error would be considered too small to merit an adjustment, is essential to avoid unnecessary payment fluctuations.

Distribution of resources in the SNF payment system

Because payments are distributed incorrectly within the SNF payment system, certain types of beneficiaries are more profitable for SNFs to care for than others. Consequently, certain beneficiaries with multiple complex needs may have more trouble accessing SNF services, and SNF providers who care for a larger proportion of these patients may have greater difficulty operating profitably within the SNF payment system.

The Commission appreciates CMS's ongoing efforts to develop a new SNF classification system, which is something MedPAC has recommended for several years now. We also commend CMS's efforts to draw on new and existing research to address ways of refining the current payment system to make payments accurately reflect the costs of caring for different types of patients within the system.

Because of the urgent need to fix the distribution of payments in the system, however, our March 2003 report urged the Congress to give the Secretary the authority to take immediate action to remove some or all of the 6.7 percent payment add-on currently applied to the rehabilitation resource utilization groups, and reallocate money to the nonrehabilitation resource utilization groups to achieve a better balance of resources among all of the groups.

The need to continue monitoring beneficiaries' access to SNF services

Beneficiaries' access to care is an important indicator of the adequacy of Medicare payments, and ensuring adequate access to care is a primary goal of the Medicare program. Because of the inappropriate distribution of payments within the SNF payment system, certain types of beneficiaries especially those with multiple complex care needs may have more difficulty accessing SNF services than others.

The Office of Inspector General (OIG) in a series of studies based on interviews with about 200 discharge planners around the country assessed beneficiaries' access to SNF services.[2] While the OIG issued these reports each year from 1999 to 2001, they did not issue a report on SNF access in 2002 and have indicated that they do not plan to continue these important reports in the future. Because MedPAC believes these studies are an important and relevant addition to the policy process, we recommend in our March 2003 Report to the Congress that the Secretary continue a series of nationally representative studies on access to SNF services.

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[2] Office of Inspector General, Department of Health and Human Services. Early effects of the prospective payment system on access to skilled nursing facilities, No. OEI-02-99-00400. Washington (DC), OIG. August 1999. Office of Inspector General, Department of Health and Human Services. Medicare beneficiary access to skilled nursing facilities, 2000, No. OEI-02-00-00330. Washington (DC), OIG. September 2000. Office of Inspector General, Department of Health and Human Services. Medicare beneficiary access to skilled nursing facilities, 2001, No. OEI-02-01-00160. Washington (DC), OIG. July 2001.

The need to promote quality of care in SNFs

As we note in our June 2003 Report to the Congress, another important goal of the Medicare program is to ensure that beneficiaries receive high-quality health care services.[3] However, the current Medicare payment system generally fails to financially reward higher-quality providers. Medicare's beneficiaries and the nation's taxpayers cannot afford for the Medicare payment system to remain neutral towards quality. Change is urgently needed. For this reason, we recommend that the Secretary conduct demonstrations to evaluate provider payment differentials and structures that reward and improve quality, and we welcome CMS's efforts to solicit comments on ways to promote quality of care in SNFs.

It is essential that CMS move as quickly as possible to develop better measures of quality of care in SNFs so we can begin to design appropriate payment incentives. Currently, the agency reports on four quality measures for skilled nursing beds. While it is useful for SNFs to focus on these few measures, they do not provide a broad picture of the quality of care for SNF patients. Additional measures focused on short-stay patients may need to be developed, such as readmissions for certain conditions. We also encourage CMS to require SNFs to report functional status (at a minimum) at the time of a patients' discharge from a SNF, to allow for comparisons between patients' status at admission and at discharge.

MedPAC believes these are important issues for the Secretary and the Congress to consider in updating fiscal year 2004 payments to SNFs and improving the SNF prospective payment system. We appreciate the opportunity to comment on these issues.

Sincerely

Glenn M. Hackbarth, J.D.
Chair

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[3] Medicare Payment Advisory Commission. Report to the Congress: Variation and Innovation in Medicare. Washington (DC), MedPAC. June 2003.