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Jon B. Christianson, Ph.D., Vice Chairman
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May 19, 2015

Andy 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-1622-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 2016, *Federal Register*, Vol. 80, No. 75, p. 22044 (April 20, 2015). 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 three sections: the proposed update, 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 1.4 percent, reflecting a market basket increase of 2.6 percent and two reductions--a 0.6 percent reduction for productivity adjustment, as required by the Patient Protection and Affordable Care Act (PPACA), and a 0.6 percent reduction as a forecast error adjustment. On net, Medicare's payments to the SNF sector are estimated to increase \$500 million in FY 2016. 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 believes no update is warranted. In March 2015, the Commission reiterated its previous recommendation that the Congress eliminate the market basket update, revise the prospective payment system, and rebase payments beginning with a 4 percent reduction to the base rate. Medicare's current level of payments appears more than adequate to accommodate cost growth, even before any update. The aggregate Medicare margin for freestanding skilled nursing facilities (SNF) in 2013 was 13.1 percent, the fourteenth year in a row that it exceeded ten percent. The Commission continues to believe major reforms are

required to correct the payment system's well established and fundamental shortcomings, and is dismayed the proposed rule neither corrects these nor lays out a timetable for revisions. Research spanning more than 13 years has identified the design features that result in patient selection, payment-driven patterns of care, and unnecessary program expenditures. Despite CMS's many refinements to the PPS, the core problems still exist. Our most recent analysis of current SNF payment policies shows that the accuracy of payments has actually deteriorated over time. Payments for rehabilitation therapy continue to exceed the costs of these services, and payments for nontherapy ancillary services (such as drugs) bear no relationship to the cost of these services. Although CMS has work underway evaluating potential revisions to the PPS, it is unclear when reforms will be implemented.

The Commission has expressed a growing impatience with the lack of progress in improving the accuracy of Medicare payments for SNF care and lowering the level of payments. It urges CMS to move forward now with a revised PPS design. At this point, the flaws of the current SNF PPS are well known, the multiple revisions to the PPS have made payments more inaccurate, and solutions are at hand. Given the acute financial pressures facing the Medicare program, the Commission asserts there is an urgent need to revise the SNF PPS. Once the deficiencies in the current PPS are corrected, CMS should proceed with the much-needed rebasing of the payment system signaled by the sector's extremely high Medicare profit margins.

Value-based purchasing

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 VBP program will vary program payments for SNF services based on the quality of care furnished using an all-cause, all-condition readmission measure. This measure must be specified by October 1, 2015. 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). Further, in assessing SNF performance, the Secretary is required to rank facility performance and consider the higher of a SNF's improvement or attainment. In this SNF PPS proposed rule, CMS proposes to use the National Quality Forum measure #2510, the SNF 30-day all-cause readmission measure, and seeks comments on measuring improvement.

The SNF 30-day all-cause readmission measure will give SNFs an incentive to provide high quality care that reduces beneficiaries' risk of poor care transitions and hospital-acquired infections and minimizes costly and disorienting readmissions. However, the measure could be improved in several ways. First, the measure includes only readmissions that occur within 30 days of discharge from an inpatient acute care hospital, critical access hospital, or psychiatric hospital. Because SNF stays often exceed 30 days (about 35 percent of stays are longer than this), using this definition will relieve SNFs of accountability for beneficiaries who have a readmission after the 30 days but who are still patients of the SNF. Further, it could create incentives for SNFs to delay needed hospital care until after day 30 to avoid including the readmission in its performance

measure. The Commission believes SNFs should be held responsible for every readmission that occurs while the beneficiary is in the SNF.

In addition, the 30-day definition does not uniformly hold SNFs accountable for a set time period after discharge from the SNF as a way to help ensure safe transitions to the next site of care (including home). By including readmissions that occur within 30 days of discharge from the *hospital*, the proposed measure may not capture any time after discharge from the SNF, depending on how long the beneficiary stays in the SNF. The Commission has stated that SNFs should be held accountable for safe transitions to the next setting for all beneficiaries, using a measure that gauges readmissions after discharge *from the SNF*. Further, to align the measure with the hospital readmission policy, the SNF measure should hold SNFs accountable for 30 days after discharge from the SNF. Because the processes and actors affecting readmissions after discharge from the SNF are likely to differ from those related to the SNF stay-based care, separate measures (one for readmissions occurring within the SNF stay and one for readmissions within some time period after discharge from the SNF) would give SNFs more actionable information and hold them appropriately accountable.

Another concern with the SNF 30-day measure is that it excludes patients admitted to SNFs from inpatient rehabilitation facilities and long-term care hospitals. We agree that these patients may be in a different phase of their recovery from an acute care hospitalization but disagree with excluding these stays from the measure. Rather, the stays should be included in the measure, with a separate risk adjustment method developed for them.

Finally, the risk adjustment method accounting for differences across patients in their risk of readmission considers the number of prior hospitalizations during the previous year. We agree that the rates need to be adjusted for differences across patients in their complexity and risk of readmission. However, factoring in the number of prior hospital stays could adjust a facility's rate for the readmissions that occurred during the previous year, including those that were potentially preventable. A better way to adjust for differences in patient risk would be to consider the hierarchical condition codes (HCC) that incorporate diagnoses gathered from physician and hospital inpatient and outpatient claims during the past year. The HCCs are more likely to capture the full risk of a patient's comorbidities than the secondary diagnoses coded during the immediately preceding hospital stay.

The proposed rule seeks comments on several design features of the performance standards for the value-based purchasing program. With regards to the performance scores, the Commission agrees that both improvement and attainment are important to motivate providers and recognizes that PAMA requires the Secretary to reward the higher of attainment or improvement. That said, because ultimately the program should care most about having all providers furnish high quality of care, this "higher of" requirement should be reconsidered so that attainment receives

higher weighting than improvement. The Commission also favors establishing specific benchmarks so that providers know their “targets” at the beginning of the performance period to receive an incentive payment.

CMS seeks comment on how improvement should be factored into the performance scoring. For clarity and transparency, the risk-adjusted readmission rates themselves should not be further modified to reflect improvement. Not modifying the rates will allow a provider to make accurate and meaningful comparisons with other providers and enable beneficiaries to select a SNF based on its readmission rate. If the readmission rates were adjusted for improvement, it would be possible for two facilities to have the same “rates” but different experiences. One facility could have a higher (worse) readmission rate but, because it improved since the previous performance period, its “rate” will be decreased to equal that of another SNF with a lower (and better) readmission rate. The different experiences of these facilities should be transparent in the publicly reported measure, with the rate being solely a gauge of each SNF’s readmissions, not a combination of the rate and improvement. How these rates are translated into performance scores and financial rewards should be an entirely different undertaking.

CMS also seeks comment on how performance scores are translated into a value-based incentive payment, the “exchange function.” The Commission supports using a linear exchange function, especially at the beginning of the program. A linear exchange function is easily understood by providers and therefore may encourage changes in practice patterns compared with a more complex function that, if poorly understood, may discourage improvement. In addition, a linear relationship gives equal importance to improvement for lower- and higher-performing SNFs and gives all providers an equal opportunity to receive an incentive payment. Over time, as CMS examines provider responses, it may elect to change the exchange function to create stronger incentives for lower-performing providers.

In terms of a performance period, a year-long time period strikes a balance between having providers treat enough cases so that the readmission rates reflect actual performance (and not random statistical variation) and yet is reasonably current to capture relatively recent practice. CMS should also consider a minimum annual case count below which data over multiple years is pooled. This would increase the number of observations in the performance period so that the measure is more statistically reliable for low-volume SNFs.

Quality reporting

The IMPACT Act of 2014 requires the implementation of quality measures and resource use and other measures that are standardized and interoperable across post-acute care settings. In addition, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals are required to report standardized patient assessment data. Implementation of a common patient assessment tool will allow the comparison of costs, quality of care, and patient

outcomes across all post-acute settings, while controlling for differences in patient condition and other characteristics that affect the cost of care or the patient's capacity to benefit from care. Those comparisons, in turn, would allow us to know what Medicare is buying in each setting and assess the value of the services furnished.

The IMPACT Act requires Medicare to implement a quality measure addressing the domain of "functional status, cognitive function, and changes in function and cognitive function." To meet this requirement, CMS proposes to use a process measure in which each PAC provider would report the percentage of its patients for whom it performed a functional assessment at admission and discharge, and developed a care plan that addresses at least one functional goal. The Commission has urged for several years that Medicare's quality measurement system should move away from clinical process measures and toward the use of outcome measures. Therefore, we do not support the process measure CMS is proposing. We urge the agency to use instead an outcome measure that reports actual changes in PAC patients' physical and cognitive functioning while they are under a provider's care, as envisioned in the IMPACT Act.

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,

A handwritten signature in cursive script that reads "Jon Christianson".

Jon B. Christianson, Ph.D.
Vice-Chairman

JBC/cc/w