MEDPAC | Medicare Payment Advisory Commission

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Chiquita Brooks-LaSure
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-1779-P

Dear Ms. Brooks-LaSure:

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 2024" in the *Federal Register*, vol. 88, no. 68, p. 21316 (April 10, 2023). 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 three main sections: (1) the proposed update to skilled nursing facility (SNF) payment rates for fiscal year (FY) 2024, including the market basket update, case-mix adjustment, and wage index adjustment; (2) the SNF quality reporting program (QRP); and (3) the SNF value-based purchasing program (VBP).

Proposed SNF PPS rate setting methodology and FY 2024 update

Market basket update factor for FY 2024, forecast error adjustment, and productivity adjustment

CMS proposes to increase the SNF payment rates by 6.1 percent. This reflects a 2.7 percent SNF market basket update minus a 0.2 percentage point total factor productivity adjustment (both required by law), plus a 3.6 percentage point forecast error adjustment. Since 2003, CMS has adjusted the market basket percentage update to reflect forecast error if the difference between the forecasted and actual change in the market basket exceeds a specified threshold (0.5 percentage point). At the time of the final rule for FY 2022, using the most recently available forecasted data, CMS finalized an increase in the SNF market basket of 2.7 percentage points. Updated data indicate that the actual market basket increase was 6.3 percentage points, a

difference of 3.6 percentage points. Because the difference exceeds the forecast error threshold, CMS proposes to increase the market basket update by 3.6 percentage points.

Comment

The Commission understands that by law CMS is required to update the SNF prospective payment system (PPS) rates by the market basket minus a productivity adjustment. After assessing indicators of beneficiary access, the volume of services, the supply of providers, and access to capital, the Commission recommended in its March 2023 report that the Congress reduce the 2023 Medicare base payment rates by 3 percent for FY 2024.[1] Not including federal relief funds, the aggregate Medicare margin for freestanding SNFs in 2021 was 17.2 percent, the 22nd consecutive year that this margin has exceeded 10 percent. Allocating a portion of the reported federal relief funds to Medicare payments, we estimate that the aggregate Medicare margin was 19.6 percent. The combination of federal relief policies and the implementation of the new case-mix system resulted in overall improved financial performance for SNFs. The high level of Medicare's payments indicates that a reduction is needed to more closely align aggregate payments to aggregate costs.

Although CMS is required by statute to update the payment rates each year by the estimated change in the market basket, the agency is not required to make automatic forecast error corrections. In this instance, an automatic forecast error correction results in making a larger payment increase in addition to the statutory increase for FY 2024, even as the aggregate Medicare margin for SNFs is high.

Case-mix adjustment

In FY 2020, CMS implemented the new case-mix system for SNFs, the Patient-Driven Payment Model (PDPM). CMS's goal was to ensure that the new case-mix system was budget neutral—that it did not increase or decrease payments compared to what would have been paid under the former case mix system. To achieve this budget neutrality, CMS multiplied the PDPM case mix indexes by an adjustment factor ("parity adjustment") that was estimated by comparing total payments under the previous case mix system to the expected total payments under the PDPM, assuming no changes in the population, provider behavior, and coding.

After PDPM implementation, CMS monitored SNF utilization to ensure that the original parity adjustment it made in FY 2020 was sufficient to achieve budget neutrality. In its analysis of FY 2020 data for FY 2022 rulemaking, CMS observed significant differences between expected and actual SNF payments and service use that warranted an additional parity adjustment to bring aggregate payments under the new case-mix system in line with what payments would have been under the prior system.[2] However, in the FY 2022 final rule, CMS did not make a parity

[1] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
[2] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2021. Medicare program; prospective payment system and consolidated billing for skilled nursing facilities; updates to the quality reporting

adjustment and stated it would reconsider the parity adjustment in the FY 2023 rule. In the FY 2023 final rule, CMS responded to stakeholders' comments and estimated that the difference between actual and expected payments warranted a parity adjustment of –4.6 percent. CMS finalized a recalibration of the PDPM parity adjustment with a two-year phase-in period, resulting in a reduction of 2.3 percent, or $780 million, in FY 2023 and a planned reduction of 2.3 percent in FY 2024.[3] Consistent with its FY 2023 final rule, CMS proposes in this rule to implement the second phase of the parity adjustment, resulting in a reduction of 2.3 percent, or approximately $745 million, in FY 2024.

Comment

The Commission supports CMS implementing the remainder of the recalibrated parity adjustment in FY 2024 to prevent continued SNF payments in excess of the intended budget-neutral implementation of the PDPM. In our comments on the FY 2023 proposed rule, the Commission considered CMS's proposed approach to estimating the parity adjustment to be reasonable and supported full implementation (rather than a two-year phase-in) of the proposed parity adjustment in that year.[4] In the FY 2023 proposed rule, CMS estimated that delaying parity adjustment recalibration resulted in the Medicare program overpaying SNFs by about $1.7 billion per year—which it cannot recoup—since the PDPM was implemented.[5]

Wage index adjustment

Since the inception of the SNF PPS, CMS has used the hospital wage data to develop the SNF PPS wage index. For fiscal year 2024, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index to adjust SNF payments (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index").

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program and value-based purchasing program for federal fiscal year 2022. Proposed rule. *Federal Register* 86, no. 71 (April 15): 19954–20022.

[3] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. 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 2023; changes to the requirements for the Director of Food and Nutrition Services and physical environment requirements in long-term care facilities. Final rule. *Federal Register* 87, no. 148 (August 3): 47502–47618.

[4] Medicare Payment Advisory Commission. 2022. MedPAC comment on 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 2023; request for information on revising the requirements for long-term care facilities to establish mandatory minimum staffing levels." June 8. https://www.medpac.gov/wp-content/uploads/2022/06/06082022_SNF_FY2023_MedPAC_COMMENT_SEC.pdf

[5] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. 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 2023; request for information on revising the requirements for long-term care facilities to establish mandatory minimum staffing levels. *Federal Register* 87, no. 73 (April 15): 22796.

Comment

The Commission has long been concerned with flaws in the wage indexes Medicare uses to adjust provider payments to reflect geographic differences in labor costs.[6] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as, but not limited to SNFs), Medicare needs wage indexes that are less manipulable, accurately and precisely reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing with each other for patients and employees. In the Commission's June 2023 report to the Congress (forthcoming), we recommend that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new Medicare wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type;
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas; and
- smooth wage index differences across adjacent local areas.

Given the Secretary's authority (42 U.S.C. §1395yy) to determine the appropriate wage index to adjust the portion of the SNF per diem rate attributable to wages and wage-related costs, we urge the Secretary to adopt the Commission's recommended approach to the wage index for this sector.

Skilled nursing facility quality reporting program (SNF QRP)

SNF QRP quality measure proposals

CMS invites comments on its proposals to adopt three new measures, remove three measures, and modify one existing measure for the SNF QRP in the FY 2025, FY 2026, and FY 2027 program years. Below we comment on CMS's proposals to add a *Discharge Function Score* measure, and to add a *CoreQ: Short Stay Discharge* measure.

Comment

Proposal to adopt a Discharge Function Score measure

CMS proposes to add a cross-setting *Discharge Function Score (DC Function)* measure to the SNF QRP beginning in FY 2025. This outcome measure evaluates functional status by calculating the percentage of SNF patients who meet or exceed an expected discharge function score (self-care and mobility activities) using the standardized patient assessment data from the SNF Minimum Data Set (MDS).

[6]Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC

Function is a key outcome for patients receiving post-acute care. At this time, we continue to caution against QRP measures based on provider-reported MDS assessment data. As we reported in our June 2019 report to the Congress, facilities' recording of functional assessment information, such as change in mobility, appear to be influenced by incentives in the applicable payment systems, rather than objective assessments of patients' function, raising concerns about using such information for the purpose of public reporting or payment.[7] In addition, we have concerns about CMS's current policy of recoding missing values of SNF MDS measures (e.g., measures coded as "activity not attempted," or ANA) to the lowest functional status. This practice, all else equal, would lead to a lower function score for a SNF patient and raise Medicare payment for the stay.[8]

While current provider-reported patient function information is flawed, beneficiaries and policymakers have a strong interest in objective information about SNFs' effectiveness in improving or maintaining their patients' functional abilities. In the Consolidated Appropriations Act, 2021 (CAA), the Congress required and provided funding to CMS to implement a process for validating the quality data used in the expanded SNF VBP. After this validation process is put in place, and if the accuracy of the provider-reported assessment data demonstrably improves, then CMS should consider including them in the SNF VBP and QRP.

Cognizant of the limitations of MDS-based measures based on our prior analyses, we nevertheless support CMS's proposal to improve the quality of the MDS data by using statistical imputation to recode missing functional status data, rather than using its current policy of assigning these values with the lowest functional status. We note that in the unified PAC PPS prototype design for CMS/Office of the Assistant Secretary for Planning and Evaluation, RTI used a Rasch analysis to recode "activity not attempted (ANA)" responses to create a motor function score for PAC users.[9] We encourage CMS to more clearly explain its proposed approach to recoding and contrast it with that used in the PAC PPS prototype, to enhance transparency and demonstrate that the proposed approach is clinically meaningful.

Proposal to adopt a CoreQ: Short Stay Discharge measure

CMS proposes to adopt the CoreQ discharge measure for short-stay residents (*CoreQ: Short Stay Discharge*) as a measure of patient experience in the SNF QRP beginning with the FY 2026 QRP. The CoreQ survey for short-stay residents includes four items that ask beneficiaries if they would recommend their facility, how they rate the staff and the care they received, and whether their discharge planning needs were met. The Commission maintains that Medicare quality

[7] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[8] In the SNF PDPM, the physical therapy, occupational therapy, and nursing components of the payment rate are adjusted based on a patient's function scores.
[9] RTI International. 2022. *Report to Congress: Unified payment for Medicare-covered post-acute care.* Report prepared for the Centers for Medicare & Medicaid Services. Research Triangle Park, NC: RTI International. https://www.cms.gov/files/document/unified-pac-report-congress-july-2022.pdf.

programs should include population-based measures tied to clinical outcomes, patient experience, and value/resource use.

Across the health care system, research finds that improving patient experience translates to better health. The Commission recently recommended that the Secretary finalize development of and begin to report patient experience measures for SNFs.[10] We therefore support CMS's proposal to adopt a CoreQ survey-based measure of patient experience for short stays. The CoreQ survey is already in use in many SNFs so it could be implemented into the SNF QRP more quickly than other surveys of patient experience. CMS's proposal to use a third-party survey vendor to collect survey results from patients (or their proxies) is consistent with the Commission's past comments about the CoreQ survey. Special care should be taken in the survey and reporting process to protect the confidentiality of beneficiaries with Medicare-covered stays who become long-stay residents in the facilities they are rating.

While we are supportive of adopting the *CoreQ: Short Stay Discharge* measure, the limited number of questions on the CoreQ survey may not fully capture patient experience. The Agency for Healthcare Research and Quality's (AHRQ's) three nursing home Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey instruments for long-stay residents, short-stay patients who are discharged, and family members include roughly 50 questions about various aspects of care, including safety, cleanliness, timeliness of nursing staff, and overall rating of the facility.[11] As CMS notes, some observers contend that the CAHPS surveys include too many questions. We encourage AHRQ and CMS to continue to refine the CAHPS survey instruments so they are shorter than their current versions but more comprehensive than the CoreQ survey. CMS should also finalize the development of CAHPS-derived quality measures that are adjusted for respondent characteristics (e.g., sex, age, education, whether a proxy completed the survey).

Skilled nursing facility value-based purchasing program (SNF VBP): Proposed policy changes

SNF VBP program measures

The FY 2024 rule proposes to refine the SNF potentially preventable readmission (PPR) measure specifications and replace the *Skilled Nursing Facility 30-Day All-Cause Readmission Measure* with the *Skilled Nursing Facility Within-Stay Potentially Preventable Readmission Measure* beginning with the FY 2028 SNF VBP program year. CMS also proposes to add four additional measures to the SNF VBP: (1) *Total Nursing Staff Turnover*, (2) *Number of Hospitalizations per 1,000 Long Stay Resident Days*, (3) *Discharge Function Score for SNFs*, (4) *Percent of Long-Stay Residents Experiencing One or More Falls with Major Injury*.

[10] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[11] CAHPS is a registered trademark of AHRQ, a U.S. government agency.

Comment

The Commission's June 2021 report to the Congress identified fundamental flaws in the design of the SNF VBP program (much of which is specified in statute and would require Congressional action to address) and recommended that a replacement SNF value incentive program (VIP) be implemented as soon as possible.[12] While the changes proposed in this rule do not address all of the design flaws of the SNF VBP, expanding the measure set under the authority granted by the CAA 2021 is consistent with the Commission's recommendation to score a small set of measures.

Proposed Skilled Nursing Facility Within-Stay Potentially Preventable Readmission measure

The Commission supports the proposed refinements of the SNF PPR measure specifications and replacing the *Skilled Nursing Facility 30-Day All-Cause Readmission Measure* with the *Skilled Nursing Facility Within-Stay Potentially Preventable Readmission Measure*. As we discussed at length in our June 2021 mandated report evaluating the SNF VBP, the Commission supports a during-SNF-stay hospital readmission measure that holds a provider accountable for the entire SNF stay rather than a measure that includes only the first 30-days after hospital discharge.[13] Readmissions that occur during the stay indicate shortcomings in the monitoring and detection of clinical conditions that, when left untreated, can worsen.

Proposed Total Nursing Staff Turnover and Number of Unplanned Hospitalizations per 1,000 Long Stay Resident Days measures

The Commission supports the proposed inclusion of *Total Nursing Staff Turnover* and *Number of Unplanned Hospitalizations per 1,000 Long Stay Resident Days* measures in the SNF VBP. Although nursing staff turnover is not an outcome measure, higher turnover rates have been associated with worse outcomes, including higher rehospitalization rates, emergency department visits, and infection rates.[14] However, CMS should continue to assess the relationship between patient outcomes and staff turnover to monitor whether providers change their behavior in ways that may lower the quality of patient care (e.g., retaining substandard staff to improve performance on the turnover measure).

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[12] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

[13] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

[14] Gandhi, A., H. Yu, and D. Grabowski. 2021. High nursing staff turnover in nursing homes offers important quality information. *Health Affairs*. 40 (3): 384–391.
Loomer, L., D. Grabowski, H. Yu, et. al. 2021. Association between nursing home staff turnover and infection control citations. *Health Services Research* 57 (2): 322–332.
Trinkoff, A., K. Han, C. Storr, et al. 2013. Turnover, staffing, skill mix, and resident outcomes in a national sample of U.S. nursing homes. *Journal of Nursing Administration* 43 (12): 630–636.
Q. Zheng, C. Williams, E. Shulman, et.al. 2022. Association between staff turnover and nursing home quality–Evidence from payroll-based journal data. *Journal of the American Geriatrics Society.* 1–9.

We support the proposal to include the *Number of Unplanned Hospitalizations per 1,000 Long Stay Resident Days* measure for several reasons. First, most long-stay residents are Medicare beneficiaries. Second, care provided in an inpatient hospital to Medicare beneficiaries who are nursing home residents is covered by Medicare (provided a beneficiary has not reached lifetime limits), thus increasing costs for the Medicare program. Finally, as CMS notes in the proposed rule, unplanned hospitalizations can be disruptive, burdensome, and risky for residents.

Proposed Discharge Function Score and Percent of Long-Stay Residents Experiencing One or More Falls with Major Injury measures

The Commission does not support the inclusion of the *Discharge Function Score* and *Percent of Long-Stay Residents Experiencing One or More Falls with Major Injury* measures in the SNF VBP. Although these are critically important aspects of quality, due to concerns about the accuracy of MDS data, we continue to caution against VBP measures—including incidence of falls and change in or attainment of function—based on provider-reported MDS assessment data at this time. Research suggests that nursing homes underreport rates of pressure ulcers and falls.[15] Because maintaining and improving function and avoiding falls with major injury are critically important to patients, it is desirable to improve the reporting of assessment data so that these outcomes can be adequately assessed.

Although not proposed, the Commission encourages CMS to consider two additional measures for inclusion in the SNF VBP—a patient experience measure and a Medicare spending per beneficiary (MSPB) measure. First the Commission encourages CMS to add the CoreQ survey-based patient experience measure (discussed earlier in this letter in the context of the QRP) to the VBP, consistent with our standing principle that quality measurement should include measures of patient experience. The Commission also encourages CMS to add an MSPB measure to the VBP, as discussed in our June 2021 report to the Congress.[16] To keep its MSPB low, a provider has an incentive to furnish high-quality care (avoiding hospitalizations), make referrals for the necessary level and amount of subsequent care, ensure safe transitions, and discharge beneficiaries to high-quality PAC providers (e.g., home health agencies) with low hospitalization rates. Paired with outcome measures, the MSPB–PAC measure could also detect stinting on care by identifying providers with consistently low spending per beneficiary and low quality. MSPB is currently publicly reported and would require no additional data collection or calculation.

Proposed case minimums during a performance period

CMS is proposing case minimums for *Total Nursing Staff Turnover*, *Percent of Long-Stay Residents Experiencing One or More Falls with Major Injury*, *DC Function*, *Number of*

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[15] IntegraMed Analytics. 2020. Underreporting in nursing home quality measures. https://www.nursinghomereporting.com/post/underreporting-in-nursing-home-quality-measures.
Sanghavi, P., S. Pan, and D. Caudry. 2020. Assessment of nursing home reporting of major injury falls for quality measurement on Nursing Home Compare. *Health Services Research* 55, no. 2 (April): 201–210.

[16] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Unplanned Hospitalizations per 1,000 Long Stay Resident Days, and the *Skilled Nursing Facility Within-Stay Potentially Preventable Readmission Measure*. For the *Total Nursing Staff Turnover* measure, CMS is proposing that SNFs have a minimum of one eligible stay during the one-year performance period and at least five eligible nursing staff (RNs, LPNs, and nurse aides) during the three quarters of Payroll Based Journal data included in the measure denominator. For *Percent of Long-Stay Residents Experiencing One or More Falls with Major Injury, DC Function*, *Number of Unplanned Hospitalizations per 1,000 Long Stay Resident Days*, and the *Skilled Nursing Facility Within-Stay Potentially Preventable Readmission Measure*, SNFs must have a minimum of 20 residents in the measure denominator during the one-year performance period to be eligible to receive a score on the measure for the applicable fiscal program year.

Comment

Minimum case counts help ensure that measure results are reliable. When measures are unreliable, the performance of one provider may appear to be different from another provider when in fact the sampling error around the estimate is so large that their performances are not statistically different from each other. Especially when tied to payment, measures should accurately reflect performance, not random variation.

The Commission urges CMS to demonstrate that proposed case minimums for proposed measures are sufficient to meet a commonly used standard of reliability (0.7, meaning 70 percent of the variation is explained by differences in performance and 30 percent is attributed to random variance). For example, in our work, we found that minimum counts of 60 stays were needed for reliable results for the measures we included in our SNF VIP design (readmissions, successful discharge to the community, and Medicare spending per beneficiary).

The Commission appreciates the trade-off between achieving reliable results and encouraging quality improvement for as many providers as possible. One way to expand the number of SNFs meeting this higher reliability standard is to include multiple years in the performance period. More recent years could be weighted more heavily than earlier years. We urge CMS to consider pooling data over multiple years to include as many providers in the VBP as possible. As we noted in our June 2021 mandated report evaluating the SNF value-based purchasing program, requiring a SNF to have at least 60 discharges would result in about 40 percent of SNFs being held harmless (not participating in the program) if using one year of data to calculate results. If that requirement is applied using three years of data, then about 10 percent of SNFs would be held harmless.[17]

Proposed application of the SNF VBP scoring methodology to proposed measures

CMS is proposing to apply the previously finalized scoring methodology to proposed new measures. CMS's methodology awards up to 10 points based on achievement, and up to 9 points

[17] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

based on improvement, so long as the SNF meets the case minimum for the measure. The higher of these two scores would be the SNF's score for the measure.

Comment

In recommending the SNF VIP, the Commission modeled its preferred scoring approach in our June 2021 report to the Congress.[18] Unlike the current SNF VBP scoring methodology that awards points for the higher of improvement or achievement scores, the SNF VIP scores only achievement using a performance-to-points scale for each measure based on the continuous distributions of all SNF scores so that providers are always better off improving to achieve a higher level of quality—thus negating the need to separately score improvement. Consistent with the Commission's 2021 recommendation, the performance scale should be revised over time as performance improves, and it should be prospectively set so that providers can set actionable performance goals and activities.

Proposal to incorporate health equity into the SNF VBP program scoring methodology

CMS proposes to adopt a health equity adjustment (HEA) that awards bonus points to top-tier performing SNFs that serve higher proportions of SNF residents with dual-eligibility status (DES) starting in FY 2027. The proposed HEA would award eligible SNFs two points for each measure if they are in the top third of performance during the performance period. The sum of these points earned for each measure is the *measure performance scaler* for a SNF. An *underserved multiplier* is then calculated for a SNF as the proportion of DES "residents" divided by the total "resident" population in the applicable program year, translated using a logistic exchange function. (CMS is proposing that SNFs with fewer than 20 percent of SNF patients dually eligible for Medicare and Medicaid do not receive an underserved multiplier and are not eligible for a HEA.) HEA bonus points are then calculated as the product of the measure performance scaler and the underserved multiplier and added to the normalized sum of all points awarded to a SNF for each measure to generate the SNF VBP performance score.

Comment

The Commission supports CMS's efforts to account for differences in the social risk of provider patient populations in the VBP scoring. In our June 2021 report, we recommended that the Congress eliminate Medicare's current SNF VBP and establish a new SNF value incentive program (VIP) that accounts for differences in patient social risk factors using a peer-grouping approach.[19] In our peer grouping approach, a SNF would earn points based on its performance relative to national performance scales, but how those points are converted to incentive payments would vary by peer group, with larger multipliers (i.e., the payment adjustment per point) for peer groups with higher shares of beneficiaries with high social risk. We noted that to ensure transparency regarding quality of care, peer grouping should be paired with public reporting of

[18] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
[19] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

SNF VIP measure results so that beneficiaries, health systems, and payers can see which SNFs are high performing or low performing compared with national, state, and peer group averages.

Under both the Commission's recommended SNF VIP and CMS's proposed approach to incorporate health equity into the VBP scoring, providers would earn points based on their performance relative to national performance scales. In CMS's proposed approach for SNFs, providers must be in the top third of all performers nationally on a measure to receive bonus points for that measure, thereby creating performance cliffs. In contrast, the Commission did not establish a minimum performance standard for earning performance points in our SNF VIP. Establishing a minimum performance standard would be more likely to exclude SNFs treating high shares of patients at high social risk because such facilities are more likely to have lower performance on quality measures.

Both the Commission's and CMS's proposed approaches also allow providers to receive higher payments if they have higher shares of low-income patients. CMS's proposed approach would accomplish this through the underserved multiplier, whereby among SNFs with equal performance bonus points, those with higher shares of DES patients (above the 20 percent threshold) would receive a higher HEA relative to those with lower shares of DES patients. In the Commission's approach, SNFs' points are converted to incentive payments, with larger multipliers (i.e., the payment adjustment per point) for SNF peer groups with higher shares of low-income beneficiaries. Unlike CMS's proposed approach for calculating the SNF underserved multiplier, our approach does not establish a minimum threshold of low-income patients for a provider to be eligible to receive an adjustment. (We note that CMS's proposed approach in the inpatient hospital proposed rule for FY 2024 for calculating the underserved multiplier in the inpatient hospital HEA does not establish a minimum threshold of DES patients.) The Commission's approach also establishes separate pools of dollars for each peer group to be distributed among its members. By establishing separate funding pools and calculating the payment adjustment by peer group, SNFs within each group compete to earn payment adjustments on a more level playing field.

While we support CMS's efforts to account for differences in the social risk of provider patient populations in the VBP scoring, the Commission urges CMS to consider further how a peer grouping approach with the features we modeled in our June 2021 report would compare to the proposed HEA, particularly with respect to impacts on payments for providers with different shares of dually-eligible patients. In addition, while we understand that most literature uses dual-eligibility to examine the association between social risk and outcomes/quality, we support CMS's continued exploration of alternative measures to the DES share, including the Part D low-income subsidy share.

For purposes of calculating the dual-eligible patient shares for each SNF, CMS notes that "total resident population" at each SNF is defined as Medicare beneficiaries identified from the SNF's Part A claims during the performance period and defines "residents with DES" as the percentage of "Medicare SNF residents" who are also eligible for Medicaid for any month during the performance period. Based on CMS's definitions, it appears that the DES share is calculated based on the SNF's population of patients with an original Medicare Part A–covered stay during

the performance period. However, CMS uses the term "resident" throughout the discussion of the proposed SNF VBP HEA methodology, even though "resident" is commonly used to describe long-stay nursing home patients who reside in the facility. We suggest CMS clarify the populations included in the numerator and denominator of the DES-share calculation. We also urge CMS not to use the word "resident" to describe the population of SNF short stay patients with original Medicare–covered stays and instead use the word "patient."

Conclusion

We appreciate the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission 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,

Michael E. Chernew, Ph.D.
Chair