

June 4, 2021

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-1746-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 2022" in the *Federal Register*, vol. 86 no. 71, p. 19954 (April 15, 2021). 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 five sections: the update for fiscal year (FY) 2022, the forecast error adjustment, a future recalibration of the parity adjustment, the quality reporting program, and the value-based purchasing program.

Update to the proposed rates under the SNF PPS

The proposed rule increases Medicare's payment rates for skilled nursing facilities (SNFs) by 1.3 percent. This reflects a 2.3 percent SNF market basket update minus a 0.2 percentage point multifactor productivity adjustment (both required by law), and a negative 0.8 percentage point forecast error adjustment. In addition, CMS proposes to exclude from SNF consolidated billing certain blood clotting factors and items related to furnishing such factors, as required by the Consolidated Appropriations Act, 2021. On net, Medicare's payments to the SNF sector are estimated to increase by \$444 million during FY 2022.

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. That said,

after reviewing many factors—including indicators of beneficiary access, the volume of services, the supply of providers, and access to capital—the Commission recommended in its March 2021 report that the Congress eliminate the update to SNF payments for FY 2022. The aggregate Medicare margin for freestanding SNFs in 2019 was 11.3 percent, the 20th consecutive year that this margin has exceeded 10 percent. Though the projected margin for FY 2022 indicated that payments might need to be reduced to more closely align them with the cost to treat beneficiaries, the lasting impacts of COVID-19 on SNFs are uncertain. Therefore, the Commission proceeded cautiously in recommending no update rather than reductions to payments.

Proposed forecast error adjustment to the market basket update

Since 2003, CMS has adjusted the market basket percentage update by a forecast error adjustment if the difference between the forecasted and actual change in the market basket exceeds a threshold it specified (currently 0.5 percentage point). For FY 2020 (the most recently available final data), the forecasted increase in the SNF market basket was 2.8 percentage points and the actual increase was 2.0 percentage points, for a difference of 0.8 percentage point. Because the difference exceeds the threshold, CMS proposes to lower the update by 0.8 percentage point. CMS invited comments on either eliminating or raising the threshold to 1.0 percentage point.

Comment

Although CMS is required by statute to update the payment rates each year by the estimated change in the market basket index, it is not required to make automatic forecast error corrections. Consistent with the Commission’s comments in 2007 on the proposed rule for FY 2008, we do not support the triggering of automatic forecast error adjustments. An automatic forecast correction would, in some years, result in making a payment increase on top of the statutory increases to the payment rates, even though the industry has sizable average Medicare margins. Eliminating the automatic adjustments would also result in more stable updates and consistency across settings in whether forecast error adjustments are made. Except for the updates to the capital payments to acute hospitals, automatic forecast error adjustments are not made to other market basket updates.

Recalibration of the parity adjustment to ensure budget neutrality

When a new case-mix classification system is implemented, CMS must estimate its impacts on payments and make a “parity adjustment” to the new payment rates so that the case-mix changes are budget neutral and do not, by themselves, increase or decrease aggregate payments to providers. In FY 2020, CMS implemented a new case-mix system for SNFs, the Patient Driven Payment Model (PDPM), and anticipated behavioral responses, most notably decreases in the amount of therapy furnished to patients. In its analysis of FY 2020 data, CMS observed significant differences between expected and actual SNF payments and service use. However,

the extent to which those differences are due to the implementation of the PDPM or to the coronavirus public health emergency (PHE) is unclear. CMS states in the proposed rule that it will attempt to disentangle the effects of the PHE from those related to the PDPM and base its recalibration of the parity adjustment narrowly on the impacts of the PDPM.

CMS states that SNF use likely changed as a result of the PHE. During the PHE, CMS has waived two requirements of coverage that affect beneficiary eligibility for covered SNF services. The requirement of a prior three-day hospital stay has been waived, and certain beneficiaries can renew coverage without establishing a new benefit period. CMS estimates that during 2020 almost 16 percent of stays used a waiver. In addition, the PHE affected the clinical mix of patients treated in SNFs in 2020. CMS estimates that about 10 percent of stays had a COVID-19 diagnosis. The proposed rule includes information indicating that waiver-related and COVID-19 stays had different average case mixes, especially for the nursing and nontherapy ancillary components, compared with non-waiver stays. To isolate the effects of the PDPM, CMS proposes to exclude the waiver-related admissions and admissions of beneficiaries with COVID-19 diagnoses from its calculation of the parity adjustment and invited comments on this approach.

CMS also observed changes in 2020 in the services provided to patients (including a 30 percent decline in the average therapy minutes per patient) that it tied to the implementation of the PDPM. Typically, to estimate the parity adjustment, CMS would calculate payments under the old case-mix system (Resource Utilization Group-Version 4 (RUG-IV)) and the new PDPM using 2020 claims and would base the adjustment on the difference in payments. However, given the reductions in therapy provision in 2020, the distribution of days across the RUG-IV groups was substantially different in 2020 compared to past trends. CMS reports that lower therapy provision would result in assignment of the 2020 days to lower-paid RUG-IV groups. Because the expected RUG-IV payments for days in 2020 would be much lower than the actual PDPM payments, a large parity adjustment would be needed to re-establish budget neutrality. CMS states that this approach would likely result in an overcorrection. To avoid this, CMS proposes to calculate what payments would have been in 2020 under RUG-IV using the distribution of days in 2019 applied to total 2020 days. CMS seeks comments on this approach.

CMS acknowledges that, with its proposed approach, the parity adjustment could result in a significant reduction to payments if applied to payment rates in a single year. Further, if implemented in FY 2022, it would give providers little time to prepare for the resulting reduced revenues. CMS seeks comments on strategies to mitigate the impacts of a potentially large parity adjustment, including a delayed implementation (e.g., a one-year delay would affect payments in FY 2023) and a phased-in reduction (e.g., any reduction would be spread over multiple years).

Comment

CMS reports significant differences between expected and actual services and payments under the new case-mix system, unrelated to the PHE, that raised payments to SNFs. At the same time, the PHE has affected the types of cases treated in SNFs: Some beneficiaries received covered

SNF care who—outside of the PHE—would not have qualified, and some beneficiaries were admitted for treatment of COVID-19. We appreciate that the pandemic has complicated the agency’s determination of whether a revised parity adjustment is needed. We also recognize there are no perfect solutions to teasing out the impacts of the PDPM from the PHE.

That said, we consider CMS’s proposed approaches to be reasonable. Using a subset of SNF users (those without a COVID-19 diagnosis or a “waiver admission”) to estimate PDPM effects in 2020 represents a sensible approximation of SNF users had there not been a PHE. This approach would avoid including in the estimate of the parity adjustment those SNF stays that appear to be atypical. Applying the 2019 distribution of days to total days in 2020 is a practical solution to estimating RUG-IV payments for 2020 stays and would avoid a potential overestimate of the parity adjustment that could later warrant correction.

The Commission supports a delayed implementation of any recalibration of the parity adjustment. Given the continued impact of the PHE on SNF providers, a delayed implementation is appropriate. However, given the high level of aggregate payments to SNFs, phased-in implementation may not be warranted. Further, CMS should keep an account of the overpayments that will have been made for policymakers to consider in establishing future updates.

Additional measures in the SNF quality reporting program (QRP)

CMS proposes to add a *SNF Healthcare-Associated Infections (HAI) Requiring Hospitalization Measure* to the SNF QRP beginning in FY 2023. This claims-based measure aims to estimate the risk-standardized rate of HAIs that are acquired during a SNF stay and result in hospitalization.

Comment

The Commission supports the inclusion of the SNF *HAI Requiring Hospitalization* measure in the SNF QRP. The Commission maintains that Medicare quality programs should include population-based outcome measures. The rate of infections acquired during a SNF stay that are severe enough to require hospitalization is an outcome of importance to beneficiaries and the Medicare program. Further, the proposed measure can be calculated by CMS, so implementing it will not be unduly burdensome for providers.

Potential future measures for the SNF value-based purchasing (VBP) program

In the Consolidated Appropriations Act, 2021 (CAA), the Congress gave the Secretary the authority to add up to nine additional measures to the SNF VBP program. CMS has historically contended that prior law limited the VBP to a single measure (hospital readmissions) to gauge the quality of SNF care provided to fee-for-service (FFS) beneficiaries. The additional measures may include measures of functional status, patient safety, care coordination, or

patient experience. In the proposed rule, CMS requested comments on whether some existing measures should be added to the program. These existing measures are currently included in the SNF quality reporting program, reported on the Nursing Home Care Compare website, or used by the nursing home industry. In soliciting comments, CMS has categorized these measures based on their data source: Medicare FFS claims, Minimum Data Set, patient-reported, survey questionnaire, and payroll-based journal.

Comment

The Protecting Access to Medicare Act of 2014 requires the Commission to review the progress of the SNF VBP program and make recommendations as appropriate on any needed improvements. The Commission's June 2021 report to the Congress (forthcoming) includes our assessment of the SNF VBP program.¹ We identified fundamental design flaws, including the use of a single outcome measure to gauge performance. The Commission also recommended a replacement SNF value incentive program (VIP) that would score a small set of performance measures, which aligns with the Secretary's new authority to add measures to the SNF VBP program. The Commission's principles for quality measurement state that Medicare quality programs should include a small set of population-based measures tied to outcomes, patient experience, and resource use.³ So that these measures are not unduly burdensome for providers to report and are less subject to recording inaccuracies, they should largely be calculated or administered by CMS, preferably based on already-reported data, such as claims data. Measure sets are expected to evolve as more measures and better data are available.

Medicare FFS claims-based measures

In addition to the current SNF VBP readmissions measure, the Commission supports the inclusion of CMS's current discharge to the community and Medicare Spending Per Beneficiary (MSPB) measures in the SNF VBP in the near term. These measures are important to beneficiaries, the Medicare program, and entities such as accountable care organizations and health systems interested in setting up networks of high-performing providers. They also capture elements of care coordination, which is a measure domain specified in the CAA. Because the measures are already in use (they are calculated as part of the SNF QRP), CMS could incorporate the additional two measures into the SNF VBP relatively quickly.

In our illustrative modeling of the SNF VIP design, we used FFS claims data to calculate two outcome measures and a measure of resource use: all-condition hospitalizations within the SNF stay, successful discharge to the community, and MSPB. These three measures are conceptually the same as the current readmissions, discharge to community, and MSPB measures used in the

¹ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

³ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

SNF VBP and QRP. However, the three measure specifications we used in the SNF VIP differ from the current CMS measures in important ways. For example, our hospitalizations-within-stay measure captures hospitalizations (including observation stays) during the entire SNF stay, not just in the first 30 days after discharge from the hospital, as does the current readmission measure. Because some SNF stays do not last 30 days while other stays are longer, the current measure mixes hospitalizations that occur during and after the SNF stay and does not hold SNFs accountable for all of the hospitalizations while the beneficiary is in the SNF. Over time, CMS should incorporate our measure refinements described in our forthcoming June 2021 report to the Congress.

We support including the new *SNF HAI Requiring Hospitalization* measure in the VBP program. Although this measure would overlap with a broader hospitalization-within-stay measure, the measure captures an outcome of importance to beneficiaries and the Medicare program.

Minimum Data Set (MDS)-based measures

At this time, we do not support CMS including measures based on provider-reported MDS assessment data. These include measures of change or attainment of mobility, skin integrity (pressure ulcers), and incidence of falls. The Commission found that the consistency of facilities' recording of functional assessment information, such as change in mobility, raised questions about using such information for quality reporting or payment.⁴ Research also suggests that nursing homes underreport rates of pressure ulcers and falls.⁵ Still, maintaining and improving these outcomes are critically important to patients, so it is desirable to improve the reporting of assessment data so that these outcomes can be adequately assessed. In the CAA, the Congress required and provided funding to CMS to implement a validation of quality data used in the expanded SNF VBP program that may be similar to the validation of inpatient quality data (i.e., chart review of some measure results for a sample of hospitals). After this validation process is put in place, and if the accuracy of the provider-reported assessment data improves, then CMS should consider scoring them in the SNF VBP program.

Patient-reported outcome-based performance measure (overall physical health status)

We encourage CMS to further explore the use of the Patient-Reported Outcomes Measurement Information System (PROMIS) questionnaire in the SNF population. The PROMIS questionnaire can be used to measure how beneficiaries rate their overall physical health. SNFs could be required to use the PROMIS questionnaire at admission and at discharge to assess

⁴ Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

⁵ 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.

improvement or maintenance of overall physical health from the patient's perspective. However, it could take investments in time and effort by CMS to implement the questionnaire and by SNFs to train personnel and conduct the questionnaires. Also, given the high level of comorbidities and cognitive impairments among SNF patients, developing patient-reported information would require the use of proxies. CMS should do more research on using the questionnaire in SNFs and weighing the costs and benefits of including this measure of a patient-reported outcome in the SNF VBP program.

Survey questionnaire (patient experience)-based measures

We support CMS considering the inclusion of the CoreQ survey as a measure of patient experience in the SNF VBP program. The Commission recently recommended that the Secretary should finalize development of and begin to report patient experience measures for SNFs.⁷ Across the health care system, research finds that improving patient experience translates to better health. Patients who feel heard and have positive care experiences report better health outcomes and are more likely to adhere to treatment plans.

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 CoreQ survey is already in use in many SNFs so it could be implemented into the SNF VBP more quickly than other surveys of patient experience. However, given the limited number of questions, the CoreQ survey may not fully reflect patient experience at a given facility.

Alternatively, the Agency for Healthcare Research and Quality (AHRQ) has developed 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.⁸ These surveys include roughly 50 questions about various aspects of care and experience during a stay, including safety, cleanliness, timeliness of nursing staff, and overall rating of the facility. Some observers contend that the CAHPS surveys have too many questions. We encourage AHRQ and CMS to continue development of a refined CAHPS survey that is shorter than its current versions but would capture more aspects of patient experience than the CoreQ survey. CMS should also finalize the development of the CAHPS surveys into quality measures that are adjusted for respondent characteristics (e.g., sex, age, education, whether a proxy completed the survey). CMS would also need to implement a process for third-party survey vendors to collect survey results from patients (or their proxies).

⁷ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the healthcare delivery system*. Washington, DC: MedPAC.

⁸ CAHPS is a registered trademark of AHRQ, a US government agency.

Payroll based journal-based measures

Staffing measures, such as risk-adjusted nursing hours per patient day and staff turnover rates, are correlated with many dimensions of the quality of care beneficiaries receive in SNFs. As such, they are good measures to publicly report so that consumers can consider this information when selecting a provider. However, when tying provider performance to payment, the Commission supports gauging provider performance using outcomes-based measures, patient experience, and resource use. The Commission has not evaluated the use of staffing-related measures in quality payment programs.

Including broader populations to gauge provider performance

CMS has requested comments on whether to include nursing home residents (i.e., residents whose stays are not covered under Medicare's SNF PPS) in the calculation of measure results for the SNF VBP. Including more patients in the measure calculations may increase measure reliability for low-volume providers and would offer a more comprehensive representation of the care furnished in the facility. However, the Commission does not support the inclusion of measures in the SNF VBP that gauge the care furnished to non-FFS beneficiaries or to long-stay residents. The SNF VBP program adjusts FFS payments for short-stay beneficiaries during a Medicare-covered stay. Therefore, the measures should gauge only the care provided to FFS beneficiaries during a Medicare-covered stay. Furthermore, it is not clear that CMS would have timely access to Medicare Advantage (MA) encounters and commercial and Medicaid claims for their inclusion in the claims-based measures. MedPAC analyses has also found that the MA encounter data are relatively incomplete.⁹

One exception to including non-FFS patients in the SNF VBP measure calculations is for patient experience measures. The Commission believes patient experience is an important measure of quality of care but to reliably measure this domain of quality, CMS may need to include non-FFS patient experience. Patient experience surveys are typically sent to patients after they receive care from a provider (in this case, discharged from the SNF). Response rates for returned surveys can be low, thus requiring the use of a provider's entire patient population to calculate reliable measure results with minimal non-response bias. For example, the average national response rate for the hospital CAHPS[®] is about 25 percent. Therefore, CMS calculates patient experience results using all of the hospital's returned surveys so that the results are reliable. When patient experience measures are scored in the SNF VBP, low survey response rates may similarly require the inclusion of non-FFS patient experience.

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.

⁹ Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Chiquita Brooks-LaSure
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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,

A handwritten signature in black ink, appearing to read "Michael E. Chernew". The signature is fluid and cursive, with a prominent horizontal line at the end that extends to the right.

Michael E. Chernew, Ph.D.
Chair