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June 21, 2017

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-1686-ANPRM

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) advanced notice of proposed rulemaking entitled, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities: Revisions to the Case-Mix Methodology" in the *Federal Register*, Vol. 82, No. 85, p. 20980 (May 4, 2017). We appreciate your staff's ongoing efforts to administer and improve the payment system for skilled nursing facilities (SNFs), particularly given the many competing demands on the agency staff's resources.

The Commission commends CMS on the proposed revisions to the SNF prospective payment system (PPS). They correct problems with the current design that were identified more a decade ago and address the key concerns of the Commission: to base payments on patient characteristics (not the amount of therapy furnished) and to better target payments for nontherapy ancillary (NTA) services (such as drugs). CMS proposes to establish separate components for NTA services and for speech-language pathology (SLP) services and to differentiate payments for days earlier in the stay for NTA services and for physical and occupational therapy.

The redesigns redirect payments away from therapy care that is unrelated to a patient's characteristics and towards medically complex care. With this redistribution, there will be less financial advantage to treating some types of patients over others and beneficiaries with complex medical conditions should experience fewer delays in getting placed in a SNF. These impacts are consistent with those envisioned by the Commission in its recommendation.

The need for reforming this payment system has been well documented by the Commission and others.^{1,2,3} Each year, the Commission reports on the continued intensification of therapy services that far outpaces the changes in the mix of patients and that the program's payments for NTA services are unrelated to the cost of these services. It first recommended that the PPS be revised in 2008.⁴ The ANPRM discusses the intensification and "thresholding" (the amount of therapy furnished clusters around the minimum thresholds for a given therapy group) of therapy services. The Office of Inspector General reported that the growth in therapy is not related to the increased severity of the SNF population and the differences between payments and costs increase as the amount of therapy furnished per day increases.⁵ The Department of Justice has successfully enforced the False Claims Act regarding fraud and abuse of therapy billing practices.^{6,7,8} The Commission's staff continue to hear that patients who require expensive drugs can be hard to place at discharge from the hospital.

The Commission is pleased that CMS is modernizing the SNF PPS after years of Commission recommendations to do so, but we are disappointed that CMS has opted to delay the implementation of its proposal with no explanation. The redesign is clearly laid out in the Advance Notice of Proposed Rule Making, multiple Technical Expert Panels were held to consider the various design features, and extensive supporting documentation is available in on-line contractor reports. The design appears ready for implementation yet the delay extends the current inequities of the PPS. Some providers will continue to furnish unnecessary care that the program will finance and some providers will continue to selectively admit patients.

Some observers have asked MedPAC how the revisions to a SNF PPS fit with its recommendations for a PPS to span the post-acute care (PAC) settings. The Commission

¹ Government Accountability Office. 1999. *Skilled nursing facilities: Medicare payments need to better account for nontherapy ancillary cost variation*. GAO/HEHS-99-185. Washington, DC: GAO.

² Government Accountability Office. 2002. *Skilled nursing facilities: Providers have responded to Medicare payment system by changing practices*. GAO-02-841. Washington, DC: GAO.

Medicare Payment Advisory Commission. 2008. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

³ Office of Inspector General, Department of Health and Human Services. 2015. *The Medicare payment system for skilled nursing facilities needs to be reevaluated*. Report no. OEI-02-13-00610. Washington, DC: OIG.

⁴ Medicare Payment Advisory Commission. 2008. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁵ Office of Inspector General, Department of Health and Human Services. 2015. *The Medicare payment system for skilled nursing facilities needs to be reevaluated*. Report no. OEI-02-13-00610. Washington, DC: OIG.

⁶ Department of Justice. 2016a. Life Care Centers of America, Inc., agrees to pay \$145 million to resolve False Claims Act allegations relating to the provision of medically unnecessary rehabilitation therapy services. News release. October 24. <https://www.justice.gov/opa/pr/life-care-centers-america-inc-agrees-pay-145-million-resolve-false-claims-act-allegations>.

⁷ Department of Justice. 2016c. Nursing home operator and director of long term care to pay \$2.5 million to settle false claims for rehabilitation therapy. News release. October 13. <https://www.justice.gov/usao-ma/pr/nursing-home-operator-and-director-long-term-care-pay-25-million-settle-false-claims>

⁸ Department of Justice. 2016b. North American Health Care Inc. to pay \$28.5 million to settle claims for medically unnecessary rehabilitation therapy services. News release. September 19. <https://www.justice.gov/opa/pr/north-american-health-care-inc-pay-285-million-settle-claims-medically-unnecessary>.

recognizes that the implementation of a PAC PPS is likely to be years away. In the interim, it is critical that the known shortcomings of the SNF PPS be corrected. Not only will fee-for-service payments be more accurate and more equitable, the improved payments will spill over into alternative payment models (such as bundled payments and accountable care organizations) and Medicare Advantage benchmarks, all of which are based on FFS Medicare. Moreover, the changes providers are likely to make under the new SNF PPS (such as matching the provision of services to the care needs of patients) are consistent with those that will be encouraged by a PAC PPS. Therefore, a redesigned SNF PPS will be a good transition to a PAC PPS.

The Commission's comments on specific design elements are organized into the following sections: calculation of the base rates, the case-mix groups, the variable per day adjustment, revisions to the therapy provision policies, interrupted stays, revisions to the MDS assessment schedule, and the level of payments under a revised PPS.

Calculation of base rates

The law establishing the PPS for SNFs, the Balanced Budget Act of 1997 (BBA), requires that the total day SNF PPS payment be based on the allowable costs reported in 1995, updated for inflation (and since then, adjusted for productivity and, when applicable, a forecast error correction). To establish the base rates for the proposed components, the current therapy component was split into two (one for physical and occupational therapy, another for SLP services) and the current nursing component was split into separate nursing and NTA components. Neither component adds to the current level of program payments, but rather redistributes them. CMS used data from 1995 to establish base rates that would resemble as closely as possible what they would have been had they been established when the PPS was first implemented (1998). The BBA also gave CMS the option to establish separate daily rates for urban and rural facilities. In the proposed rule, CMS proposes to retain separate rural and urban base rates.

Comment

Over many years, the Commission has commented that the payment adjusters for rural location are not well targeted to those providers needed to maintain beneficiary access to care. Low-volume providers can lack economies of scale and this can increase their unit costs. However, low volume is not a sufficient measure to gauge whether higher payments are necessary since low-volume providers can be located close to each other and, in this case, are not necessarily essential to beneficiary access. Therefore, the Commission urges CMS to consider a single base rate with an empirically-based adjuster that targets payments to only isolated providers with low volume. In the Commission's work on a consolidated PAC PPS, our analysis did not indicate the need for a broad rural adjustment.

The case-mix groups

CMS proposes separate case-mix groups for the nursing, PT and OT, SLP, and NTA components. SLP services were split out from PT and OT because these services are not

correlated with each other and the factors shaping their costs differ. NTA services were split out from the nursing component because NTA costs do not vary with nursing costs and are much more variable.

The four classification systems vary by component but each is based on some combination of patient characteristics and extensive service use (such as ventilator or tracheostomy care) (Table 1). Each day is assigned to one case-mix group for each of the four case-mix components. The fifth component, the non-case-mix group, covers the room and board costs. Payments for this component are uniform for all days. The five components' payments are summed to establish the payment per day.

Table 1. The five components of the proposed SNF PPS design

Component	Case-mix grouping
Physical and occupational therapy	30 case-mix groups based on: 5 clinical categories, function, and cognition
Speech-language pathology	13 case-mix groups based on: 2 clinical categories; swallowing difficulty or mechanically-altered diet; and SLP-related comorbidities or cognitive impairment
Nursing	43 case-mix groups based on: clinical information from SNF stay, extensive services received, depression, and restorative nursing services
Nontherapy ancillary services	6 case-mix groups based on points awarded for comorbidities and extensive service use (e.g., IV medication, chemotherapy, ventilator care). HIV/AIDS adds the highest number of points of any item.
Non-case-mix group (room and board)	Uniform payment for all days

Comment:

The proposed case-mix groupings are consistent with prior work done by the Commission on the SNF PPS and the consolidated PAC PPS. This work identified factors that raise or lower the cost of care.

Regarding the SLP group, the Commission is concerned that two of the risk adjusters (swallowing difficulty and mechanically altered nutritional approach) may be susceptible to manipulation by providers. The inclusion of these factors as payment adjusters could encourage clinicians to record swallowing difficulty or change the nutritional approaches for a patient. Similarly, the proposed scoring in the NTA component includes IV medications that also change provider behavior. The Commission supports the inclusion of these items as risk adjusters when they are tied to medical necessity. For example, payments could be adjusted only when the patient has a diagnosis and comorbidities that typically require the use of mechanically altered food or is usually accompanied by difficulty swallowing. CMS could also consider requiring a physician signature to attest that the reported service was reasonable and necessary and including

a statement adjacent to the signature line warning that filing a false claim is subject to treble damages under the False Claims Act.

Variable per day adjustments

CMS proposes to adjust the daily payments for PT and OT services and NTA services to reflect their higher costs at the beginning of a stay. The adjustments for the two components are different to reflect these services' costs. Payments for PT and OT services decline steadily throughout the stay, while payments for NTA services are much higher for Day 1 through Day 3, and then are uniform for Days 4 through the end of stay.

Comment:

The current day-based PPS encourages providers to extend the lengths of stays. This is because days at the end of the stay typically have lower costs than days at the beginning of the stay. The Commission supports the per day adjustments because they more accurately reflect the cost of care.

Revisions to therapy provision policies

Since the inception of the SNF PPS, the mix of therapy modalities (individual, in groups, or concurrently) has shifted as providers responded to the payment incentives of a PPS and then to policy changes enacted to curb potentially inappropriate provider behavior. Initially, most therapy provided was on an individual basis. As the use of concurrent and group therapy increased, CMS set limits on the number of patients who can be treated at one time by a therapist (in groups and concurrently) and capped (at 25 percent) the share of total minutes that can be furnished in group therapy. It also allocated the group and concurrent minutes to more accurately reflect the lower resource requirements of these modalities. CMS reports that these modalities now comprise less than one percent of therapy minutes.

Based on prior provider behavior, CMS proposes to cap (at 25 percent) the share of therapy minutes furnished concurrently. CMS is concerned that when therapy minutes no longer count in assigning patient days to a case-mix group for payment, providers will increase the use of concurrent therapy. CMS states that group and concurrent therapy may be appropriate in some cases, but it believes individual therapy should be the principal therapy modality.

Comment:

The Commission supports this restriction. In its comment letters in 2010 and 2011, the Commission stated that it is important to have policies in place so that providers select therapy modalities based on their clinical appropriateness, not their financial advantage. While the rules are blunt instruments, past provider behavior indicates they are needed. The proposed limits strike a balance between giving providers latitude in the mix of therapy modalities while ensuring that individual therapy makes up the majority.

Interrupted stays

CMS proposes an interrupted stay policy to address situations when a patient is discharged from a SNF and returns to the same facility within 3 days. If there is more than a 3-day gap, or the admission is to a different SNF, the readmission is considered a new stay.

CMS reports that about $\frac{1}{4}$ of SNF use involves multiple stays. Without an interrupted stay policy, the second stay would restart the counting of days in the per day adjustment (with higher payments in the early days for SLP services and PT and OT) even though the adjustment is intended to reflect the increased costs of the early portion of a single stay. CMS is also concerned that the front-loaded payments could encourage some providers to discharge and then readmit a patient to restart the day counter.

Comment:

The Commission supports the adoption of an interrupted stay policy. Both IRFs and LTCHs have interrupted stay policies and both use 3 days as a threshold. Further, adding an interrupted stay policy begins the alignment of institutional PAC policies that will be required under a unified payment system.

Revisions to the MDS assessment schedule

CMS proposes to streamline the required assessments since the case-mix groups will rely on patient characteristics that typically do not change over time or can be gathered at the first assessment. Consistent with current requirements, if a patient's condition changes during the stay, a provider would be required to complete a Significant Change in Status assessment. Similar to the proposed interrupted stay policy, a change in condition would not re-start the counting of days for the per day adjustments.

Currently, Medicare requires providers to conduct scheduled assessments on Days 5, 14, 60, and 90. Unscheduled assessments may be required for certain events, including the start of therapy, the end of therapy, a change in therapy, and when there is a significant change in condition. Under the proposed schedule, providers would be required to conduct assessments on Day 5, at discharge, and when there is a significant change in condition.

Comment:

The Commission supports reducing the reporting requirements for providers. However, CMS should consider requiring that the first assessment be conducted within a narrow window of time, such as within three days of admission. Currently, the reference date for the first (Day 5) assessment is any day between Days 1 and 8 of the stay. This range undermines the uniformity of "at admission" and by Day 8 does not gauge the patient's condition at admission. An admission assessment conducted within three days of admission would align the assessment window with IRF and LTCH requirements (both 3 days) and be more consistent with the HHA requirements (within 5 days).

The level of payment under a revised SNF PPS

CMS solicited comments on whether the new classification system should be implemented in a manner that is not budget neutral.

Comment:

The Commission supports an approach that would implement the revised PPS in a manner that is not budget neutral to the current level of aggregate spending on SNF services. In its March 2017 report, the Commission noted that program payments to SNFs are high. In 2015, the Medicare margin (a comparison of the fee-for-service payments with the cost of treating these beneficiaries) was 12.6 percent. This was the 16th year consecutive year that the Medicare margin was above 10 percent. After examining many factors—including the Medicare margin, volume and access to services, the considerably lower rates paid by many Medicare Advantage plans, and quality of care—the Commission concluded that the PPS exerts too little financial pressure on providers. Further, broad payment reforms (such as bundled payments and accountable care organizations) and Medicare Advantage rely on FFS payments as benchmarks, so the accuracy and level of Medicare’s FFS payments is paramount.

With these conditions in mind, the Commission recommended that payments not be increased for two years (eliminating any market basket updates during those years) while a revised PPS was implemented, followed by an assessment and additional adjustment to payments if needed to align payments with the cost of care. CMS may prefer a different approach that effectively lowers the level of payments. As long as the adjustment is reasonable and does not disturb the empirically-based differences in payments across the case-mix groups, the Commission would support an approach that is not budget neutral.

MedPAC appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. In particular, we are gratified to see the agency begin to modify the SNF PPS consistent with the recommendations made by the Commission for many years. 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 black ink that reads "Francis J. Crosson M.D." in a cursive style.

Francis J. Crosson, MD
Chairman