MEDPAC Medicare Payment Advisory Commission

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June 24, 2011

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1518-P
P.O. Box 8011
Baltimore, Maryland 21244-1850

Re: File Code CMS-1518-P

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule entitled "Medicare Program; Prospective payment system and consolidated billing for skilled nursing facilities; Disclosures of ownership and additional disclosable parties information," published in the *Federal Register*, vol. 76, no. 88, pages 26364–26429. This proposed rule updates the payment rates for skilled nursing facilities (SNFs) for fiscal year (FY) 2012. We appreciate your staff's ongoing efforts to administer and improve payment systems for skilled nursing facilities, especially considering the competing demands on the agency.

In this letter, we comment on several aspects of the proposed rule, including:

- the proposed update that includes recalibration of the parity adjustment,
- changes in the counting of group therapy minutes and the requirements to conduct patient assessments, and
- future approaches to pay for nontherapy ancillary and rehabilitation therapy services.

The proposed update that includes recalibration of the parity adjustment

In the proposed rule, CMS outlines two possible approaches to updating payments—updating payments with and without recalibration of the parity adjustment. Revisions to a classification system can inadvertently raise or lower aggregate payments even though the complexity of the patients remains the same. In FY 2011, many changes were made to the classification system, including new case-mix groups, revised definitions of existing groups, and the allocation of concurrent therapy minutes in assigning days to rehabilitation case-mix groups. To ensure that the introduction of these changes to the classification system did not increase payments, CMS used the

best data available at the time to adjust payments. This adjustment, referred to as the parity adjustment, was designed to ensure that aggregate payments for a given set of days would be the same under the "new" classification system as under the "old" system.

In its discussion of the option that includes the parity adjustment, CMS acknowledged that its estimate of the adjustment required to keep payments budget neutral was inaccurate. For FY 2011, CMS changed the rules to classify days with concurrent therapy, allocating these minutes as a way to more accurately reflect the lower cost of this modality compared with individual therapy.[1] For example, if a patient received 500 minutes a week of concurrent therapy, the minutes used to classify the days into a case-mix group would be divided by the number of patients (two) who may receive different services at the same time by a single therapist. As a result of how the classification system now counts concurrent therapy minutes, payments for days with this modality are lower than they had been under the old classification system because the days are assigned to lower-payment case-mix groups. To estimate the size of the parity adjustment, CMS assumed providers would continue to furnish therapy concurrently, thus requiring a large positive adjustment to payments under the new classification system to make it budget neutral. Without this adjustment, payments under the new classification system would have declined.

However, CMS reports that providers shifted the mix of therapy modalities they furnish, with most therapy furnished individually and almost no concurrent therapy being provided. Claims from the first quarter of this fiscal year show a very different distribution of rehabilitation case-mix groups mix than CMS had assumed in establishing the size of the adjustment needed to maintain budget neutrality. As a result of the shift in therapy modalities, spending is considerably higher (about $4.47 billion, or about 13 percent of OACT's projected spending for 2011) than CMS estimated. Had CMS accurately predicted this shift in modalities, it would have made a smaller adjustment to payments last year to ensure budget neutrality and overpayments would not have occurred. The proposed revision to the parity adjustment for FY 2012 will bring the level of payments back to spending levels prior to the changes to the classification system.

The shifts in therapy modalities do not appear related to shifts in patient severity, as measured by the ability to perform activities of daily living. Prior to the changes in the counting of concurrent therapy minutes, CMS reported that this modality made up 28 percent of the therapy minutes. After the rule change, SNFs cut the provision of concurrent therapy and increased the provision of individual and group therapy. Because minutes are not allocated when group and individual modalities are provided, the days qualify for higher payments than they would have if concurrent therapy been furnished. CMS reported that concurrent therapy made up less than 2 percent of therapy minutes during the first quarter of 2011. Yet our analysis of patient assessment data for 2010 and first quarter 2011 found there were not large changes in patients' ability to perform activities of daily living.

[1] Concurrent therapy is the practice of treating multiple patients, who are engaged in different therapy activities, at the same time by a single therapist.

The Commission supports the option to update payments and recalibrate the parity adjustment. As a first step, CMS should revise the parity adjustment so that payments under the new classification system equal those that would have been made prior to the changes. CMS should continue to monitor whether payments continue to rise as a result of the changes made to the classification system and, if they do, make a future adjustment. In addition, the Commission supports a retrospective adjustment to recover the overpayments that occurred in FY 2011. The adjustment CMS proposes to make brings the daily payment rates back to their correct level but does not recover the overpayments that occurred this year. CMS should recoup the estimated overpayments for FY 2011 by temporarily lowering payments beginning in FY 2013. To minimize the financial impact of the reduction, payments could be lowered over more than one year, making smaller reductions over multiple years. After the overpayments have been paid back, rates would be restored to prior levels. At the same time, CMS should also implement the Commission's past recommendations regarding the design of the prospective payment system. The recommended design would base payments on a beneficiary's care needs, rather than the services provided, and target payments for patients with complex care needs, including those with high nontherapy ancillary service costs. These changes would help ensure an equitable payment system and protect beneficiaries with high-cost care needs and the facilities that treat them.

With regard to the specific design of the parity adjustment, the Commission appreciates that CMS has limited options to achieve budget neutrality and direct payments away from therapy care. The Commission has stated that CMS needs the authority to revise the base rates so that the agency has maximum flexibility to match payments to costs. In FY 2011, CMS achieved budget neutrality between the old and the new classification systems by raising payments for the nursing component for all case-mix groups. To lower aggregate payments back to the correct level, CMS plans a similar but even more targeted approach for FY 2012: It plans to lower payments for the nursing component of only the rehabilitation case-mix groups. This strategy will accomplish two things. First, it will restore budget neutrality between the old and the new classification systems and, second, it will shift funds away from therapy care and toward days for medically complex patients. The Commission has noted that such redirection is necessary to avoid overpaying for therapy services and underpaying for medically complex care. Because CMS does not have statutory authority to change the base rates, it uses the levers it has—revising the relative weights—to accomplish these goals. CMS needs to seek additional authority from the Congress to revise the base payments for the nursing and therapy components, and the Commission intends to bring up this issue again during its discussion of the adequacy of payments this fall.

Our analysis suggests that the proposed recalibration plus recoupment of current overpayments should not jeopardize the care furnished to Medicare beneficiaries. In 2009, the most recently available cost report data, the aggregate Medicare margin for freestanding SNFs was over 18 percent. We estimated the Medicare margin for 2011 to be 13.6 percent if the increase in case-mix complexity continued, which first quarter of 2011 claims data appear to confirm. This estimated margin did not consider the overpayments for 2011 that would increase the aggregate Medicare margin above 13.6 percent. In addition, the Commission has work underway to examine the need

for SNF payments to be rebased so that Medicare does not continue to overpay for SNF services. Rebasing the base rates would allow CMS to accurately reflect providers' current costs and reestablish relative weights that reflect the resource differences across the case-mix groups.

Changes in the counting of group therapy minutes and the requirements to conduct patient assessments

The Commission supports CMS's proposed method to revise the counting of group therapy minutes in classifying days into case-mix groups. Currently, all group therapy minutes are counted toward qualifying a day into a case-mix group, treating them the same as individual therapy. Yet because the costs of providing group therapy are far lower than those for individual therapy, CMS proposes to allocate group therapy minutes across the patients assumed to be in a group, thus more accurately mirroring their cost. Last year, the Commission discussed the need to allocate group therapy minutes similar to the approach taken with concurrent therapy so that payments and costs are aligned. If payments for each modality (concurrent, group, and individual) do not reflect the differing costs to produce them, providers will have financial incentives to furnish one modality over another, regardless of whether the modality is the most clinically appropriate for the patient. CMS's analysis of the current distribution of modalities indicates that a shift to the higher payment case-mix groups is occurring this year in response to the changes made to concurrent therapy. The proposed revision will result in a classification system that treats group and concurrent therapy consistently, helps ensure that payments for group therapy better match the costs to furnish it, and encourages facilities to furnish therapy modalities based on patients' clinical care needs.

The Commission also supports the proposed assessment requirements to eliminate the overlap in assessment periods and to require providers to indicate when therapy services have stopped or changed. These requirements aim to calibrate Medicare's payments to the resources required and received by patients. Currently, one patient assessment may cover some of the same days as a subsequent assessment, especially during the first few weeks of a patient's stay. Overlapping assessment periods undermine the purpose of the assessment—to represent the changing status of the patient to most accurately pay for their care needs. Another inaccuracy in payment can occur when providers do not complete an end-of-therapy assessment to indicate when therapy services have not been furnished for three consecutive days. In this case, providers continue to be paid for a rehabilitation case-mix group even though the patient is no longer receiving these services. Other inaccuracies can occur when providers do not complete timely revised patient assessments to reflect when the intensity of therapy has changed. Currently, a provider may be paid as if one level of therapy is being furnished, even though the intensity of therapy has changed. The Commission encourages CMS to monitor the completion of patient assessments for the end of therapy and changes to therapy so that payments match the therapy services furnished.

Future approaches to pay for nontherapy ancillary and rehabilitation therapy services

The proposed rule outlines possible future approaches CMS may take to pay for nontherapy ancillary (NTA) services and rehabilitation therapy services. Since 2007, the Commission has highlighted the shortcomings of the prospective payment system (PPS) design that create

incentives for SNFs to avoid patients who require high-cost NTA services and to furnish therapy services for financial, rather than clinical, reasons. We urge CMS to correct both problems as quickly as practicable.

In the case of NTA services, CMS is considering a three-part design: a base payment for routine NTA services (such as laboratory tests and low-cost drugs commonly furnished to SNF patients), a separate tiered payment for high NTA care needs, and an outlier policy targeting stays with exceptionally high-cost NTA services. Based on work funded by the Commission, researchers at the Urban Institute have found that it is possible to design an NTA component that meets CMS's criteria for such a component and improves the accuracy of payments for these services. The Commission believes the NTA design CMS has outlined is a good step in the right direction. Our work on the design of an outlier policy found that a broader outlier definition (to include stays with exceptionally high-cost total ancillary costs) would result in a policy that does not favor stays with exceptionally high NTA costs over those with exceptionally high therapy costs. The Commission looks forward to reviewing more specific details about the NTA component's design and outlier policy when it becomes available.

CMS also laid out possible future initiatives to base therapy payments on patient characteristics, not service provision. The Commission strongly urges CMS to move in this direction. Continued growth in intensity of therapy provision and Medicare margins are evidence that providers have an incentive to increase the amount of therapy they provide for financial, not necessarily clinical, reasons. In 2008, the Commission recommended that CMS revise the therapy component to be based on predicted patient care needs. Although CMS has shifted payments away from therapy services, it has not changed the underlying fee-for-service nature of therapy payments. CMS needs to overhaul the therapy component of the SNF PPS so that payments vary with care needs, not service provision.

The Commission has discussed the problem that fully prospective payments would create incentives for providers to stint on service provision and outlined two options to dampen these incentives. First, CMS could tie a portion of payments to patient outcomes (such as rates of potentially avoidable hospital readmissions and discharges to the community) so providers could not benefit financially from stinting on service provision. This would be consistent with the Commission's previous recommendation to link SNF payments to beneficiary outcomes. A second option would be to base payments on costs when a provider's actual provision of services diverges markedly from the predicted amount. Under this policy, when a provider furnished far fewer services than was predicted for a patient, the provider would be paid its actual costs, not the predicted amount. A provider could furnish far fewer services than was predicted for a patient, but it could not benefit financially from doing so. The home health care PPS has a similar adjustment for episodes with very few visits.

CMS also discussed two alternatives to fully prospective payments for therapy services. In one version, therapy payments would be based on a blend of a prospectively determined amount and

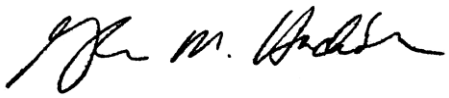
actual service provision. This approach would dampen but not eliminate the incentive to furnish therapy services as a way to raise payments. In the second, CMS suggested that it could annually recalibrate the relative weights associated with the case-mix groups. This option does not address the fundamental incentive to furnish therapy services. The Commission encourages CMS to pursue a design that bases the entire payment on patient and stay characteristics and discourages the provision of therapy as a way to boost payments.

Conclusion

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.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

GMH/cc/wc