MEDPAC Medicare Payment Advisory Commission

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June 29, 2009

Charlene Frizerra
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 310-G
200 Independence Avenue, SW
Washington, DC 20201

Re: File code CMS-1410-P

Dear Ms. Frizerra:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010; Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities; Proposed Rule,* Federal Register, Vol. 74, No. 90, p. 22208 (May 12, 2009). We appreciate your staff's ongoing efforts to administer and improve the payment system for skilled nursing facilities, particularly given the agency's competing demands.

The proposed rule includes a much-needed overhaul of the classification system and the patient assessment tool, the Minimum Data Set (MDS), used to establish payments in the skilled nursing facility prospective payment system (SNF PPS). The numerous proposed changes will affect payments for nursing and therapy services. Several changes—the expanded number of special care case-mix groups, many of the revised assessment measures within the MDS, and the updated the staff times used to establish the nursing and therapy relative weights—aim to improve payment accuracy. Consistent with a long-standing Commission recommendation, the "look-back" period for the initial patient assessment will be eliminated so that payments will reflect only the services furnished during the SNF stay. CMS also plans to revise the MDS schedule of required assessments so that all patients will be assessed at discharge, another of the Commission's recommendations.

Although the proposed rule includes many important revisions to the SNF PPS, the Commission is concerned that CMS has not proposed to correct two other well-known problems that affect payments for nontherapy ancillary (NTA) services (such as drugs and respiratory care) and therapy services. For many years, the Commission has highlighted the fundamental shortcomings of the PPS design and urged CMS to correct them. Last year, the Commission recommended that you revise the PPS to better target payments for NTA services and to dampen the incentive to furnish therapy services for financial, rather

than clinical, reasons. In a letter to CMS in February 2009, the Commission discussed the distortions in the current PPS and the resulting inequities for certain types of SNF patients, and the facilities that treat them, with the hope that CMS would address these issues in the 2010 SNF proposed rule. Unfortunately, the proposed rule does not alter the basic PPS design for NTA and therapy services. While progress is being made, it is clear that revisions to the way payments are made for NTA services are at least a year away and that there is no specific plan to move away from fee-for-service payments for therapy services.

The proposed rule also considers changes to how concurrent therapy is treated in establishing therapy payments and the adjustments made to ensure that aggregate payments do not increase or decrease as a result of changes to the classification system. We support revisions that improve the accuracy of payments and offer several technical comments to the proposed changes.

Payments for nontherapy ancillary services

Although CMS plans to add a separate component to the PPS to pay for NTA services in a future proposed rule, this year's rule does not correct the flaws in the current PPS design that were identified almost 10 years ago.[1] Without correction, payments will continue to be relatively too high for patients with below average NTA costs and relatively too low for patients with high NTA care needs. In our March 2009 report, we noted that the number of SNFs willing or able to treat patients with medically complex care needs (those who need high-cost NTA services) had declined between 2002 and 2006, and that this likely reflects the mismatch between costs and payments for NTA services. The Commission is especially concerned that CMS has not corrected this problem because policy options that would make substantial improvements in payment accuracy have been known for several years. Although the proposed changes add many case-mix groups for medically complex patients, payments for NTA services continue to be tied to staff time, which is a poor predictor of NTA costs.

In considering revisions to the PPS to pay for NTA services, CMS seeks comments on its proposed criteria for establishing a separate payment component. The Commission agrees with these criteria except for the exclusion of diagnosis information from the hospital. As we have stated before, the Commission believes this information is essential for proper patient handoffs between the hospital and SNF. Until accurate diagnosis information is gathered by SNFs, hospital diagnoses should accompany every patient transferred from a hospital to a SNF. This information transfer can be easily accomplished by simple means, such as faxing a hospital discharge summary to the receiving SNF. Furthermore, our work found that diagnosis information would improve the accuracy of NTA payments.

CMS states that it will consider an outlier policy for NTA services but recognizes that it will need Congressional authority to do so. The Commission recommended to the Congress that an outlier policy be added to the SNF PPS but emphasized that outlier policies should be reserved to mitigate financial losses that arise from the unpredictable variation in costs among individual patients. Further, our work

[1] In 2000, CMS proposed revisions to the PPS that were subsequently dropped when the results could not be validated. In 2004, researchers under contract to CMS identified policy options that would have increased the accuracy of payments for NTA services but CMS did not propose any corrections to the underlying problem in the PPS design. In 2008, based on work conducted by researchers at the Urban Institute, the Commission proposed an alternative approach that would have substantially improved the targeting of payments to NTA services.

found that a small share of stays had exceptionally high therapy costs, which suggests the need for a broadly specified outlier policy such as one focused on all ancillary services.

Payments for therapy services

Despite the Commission's long-standing concern about the PPS's incentives to furnish therapy for financial gain, the proposed rule does not change the fee-for-service aspect of therapy payments. CMS states that using a predictive model to establish therapy payments could result in under provision of therapy care and adds complexity without improving predictive power of an alternative design. We acknowledge that stinting is a possibility with any prospectively determined payment but have previously outlined an approach—much like that already used in the episode-based home health care PPS—that would counter this incentive. Regarding the accuracy of an alternative design, work conducted for us by researchers at the Urban Institute found that predictive models could explain almost as much of the variation in treatment costs as current policy but with two significant advantages. First, by basing payments on predicted care needs, SNFs would have no incentive to furnish therapy for financial rather than clinical reasons. Second, a predictive model would reduce the large overpayments that are now made for stays with high amounts of therapy.

Predictive models may appear complicated to providers because there is not an established set of case-mix groups with a schedule of payments. Because payments would vary with each patient's care needs and stay characteristics, they can better reflect the wide differences across patients. While a pre-set number of case-mix groups may be more convenient for providers, a predictive model is more likely to be better for beneficiaries. Predictive models have precedent: one is used for Medicare payments to psychiatric hospitals.

CMS mentioned that stakeholders have expressed serious reservations about using diagnoses to predict therapy care needs. We agree with stakeholders that diagnoses alone should not be used to predict therapy care needs. However, our work found that adding patient diagnoses from the prior hospital stay would improve our ability to predict SNF patients' use of therapy and therefore would help improve SNF payment accuracy for therapy services. Until better diagnosis information is collected by SNFs, we believe CMS should include hospital diagnoses, along with other patient and stay characteristics, to establish SNF payments. CMS stated it would be premature to implement a predictive model before it has results from the Post Acute Care Payment Reform Demonstration and a project examining facility compliance with the inpatient rehabilitation facility PPS. The Commission is concerned that this will delay much-needed reforms until well after 2012.

On a separate issue related to therapy payments, the Commission supports revisions that will more accurately reflect when therapy services are furnished to beneficiaries. The proposed changes would prevent Medicare from paying for therapy services that were ordered, scheduled, or discontinued but not actually furnished to patients. Other changes would revise the reporting requirements so that patients can be assigned to rehabilitation and non-rehabilitation RUGs based on when therapy services are started and stopped. These proposed changes will increase the accuracy of payments to providers.

Payments for concurrent therapy

CMS proposes to change the way therapy minutes are counted when the therapy is furnished "concurrently" to more accurately reflect the resources used to provide care.[2] Under current policy, concurrent therapy minutes are counted the same as individual therapy time in assigning patients to case-mix groups. SNFs have a financial incentive to provide therapy concurrently because it is less costly to furnish than individual therapy. Although concurrent therapy has become the predominant mode of therapy provision to SNF patients, CMS states that individual therapy should be the primary mode of delivery. Under the proposed rule, CMS would require therapists to allocate their time across the patients seen concurrently and only the allocated minutes would count towards classification into a case-mix group. This new counting would shift many patients into lower case-mix groups than if all of the time was counted.

The Commission agrees with CMS that payments should accurately reflect the resources required to furnish therapy services but has technical comments about the proposed revisions. The amount of time a patient spends in individual or concurrent therapy is identical; what changes is the cost of the therapist's time. We believe that all concurrent therapy minutes should count in assigning a patient to a case-mix group because the patient and the amount of services received have not changed. To reflect the lower costs to produce concurrent therapy, the costs of the therapist's time should be allocated across the patients who receive therapy at the same time. Thus, if a therapist saw four patients in a one-hour session of concurrent therapy, each patient's 60 minutes would count towards classification into a RUG but the *cost* to produce the hour would be one-quarter of the therapist's hourly cost. In this alternative approach, the relative weights would reflect the costs to furnish the care—the therapist's time and the mix of individual and concurrent therapies—to the patients in each RUG.[3]

Using this same logic, group therapy also costs less to produce than individual therapy.[4] Consistent with the suggested approach to concurrent therapy, group therapy minutes should count towards assigning a patient to a case-mix group and the therapist's time should be allocated across the patients in the group to calculate the cost to produce each patient's hour of group therapy. This suggested change would result in identical treatment of concurrent and group therapy minutes, and make both consistent with the billing for therapy services under part B.

The shift from individual to concurrent therapy highlights the need for CMS to have information about the relative effectiveness of different therapy modalities and whether group size matters when group or concurrent therapy is furnished. Absent this information, we propose an approach that is neutral to the therapy modality and group size but reflects the cost differences of producing individual versus group or

[2] Concurrent therapy is the practice of treating multiple patients, who are engaged in *different* therapy activities, at the same time.

[3] To establish the therapy relative weights of the rehabilitation RUGs, CMS can use information on the therapy times and modalities by RUG gathered from the STRIVE data for facilities whose data appeared consistent throughout the therapy data collection period. CMS would consider the full cost of individual therapy minutes, the allocated costs of group and concurrent therapy minutes, and the mix of therapy modalities (group, individual, and concurrent) in each RUG to establish the therapy payment for each rehabilitation case- mix group.

[4] Group therapy is the practice of treating multiple patients, who are engaged in the *same* therapy activities, at the same time.

concurrent therapies. If patient outcomes differ by therapy modality, a pay-for-performance policy would create incentives for providers to furnish the most effective mix of therapy services.

The shift in therapy modalities from individual to concurrent therapy also underscores the lack of an effective way to regularly update the relative weights so that SNF payments keep pace with current practices. The recalibrated relative weights as we propose will "freeze" the mix of individual, concurrent, and group therapy visits in each RUG until the next update is completed. In other PPSs, shifts in practice and the relative costs of services are captured through scheduled updates to the relative weights. However, CMS does not have a regular update process for the SNF PPS relative weights and its method does not use easily-obtained administrative data. Rather, CMS gathers staff times from facilities, which is expensive and therefore conducted infrequently. The recent STRIVE data collection was the first effort to update the relative weights since the payment system was implemented more than ten years ago using data from 1995 and 1997.

The Commission has previously discussed the need for CMS to establish a low-cost way to gather patient-specific costs. One idea is to parallel what is done in other PPSs: require providers to submit charges for services in sufficient detail (including the date of service) so that it is possible to estimate the relative resource intensity of individual patients from charge information. Together with data from the cost report (that should require the recording of nursing costs), CMS could then convert the charges to costs, thereby establishing a reasonable approximation of patient-level costs, consistent with the practice in other PPSs.

Parity adjustments

Refinements to a classification system and its relative weights can inadvertently raise or lower aggregate payments, without any real change in patient complexity or providers' cost of furnishing care. To ensure that the introduction of the case-mix changes is budget neutral, CMS uses the best currently available data to make an across-the-board adjustment to payments so that payments under the "new" case-mix system are the same as payments would have been under the "old" system based on the same cases. This is the so-called parity adjustment. After their implementation, case-mix refinements often lead to an unwarranted increase in payments and the size of the increase can not be accurately predicted at the time the classification changes are adopted. Once the increase in aggregate payments can be measured, CMS generally revises its estimate to prevent further overpayments from occurring.

The proposed rule describes two parity adjustments: a revised estimate of the impact of adding nine case-mix groups back in 2006 and a new parity adjustment to ensure budget neutrality with the adoption of the RUG-IV classification system. The Commission has technical comments on both adjustments.

Parity adjustment for 2010: CMS acknowledged that the parity adjustment made in 2006 substantially underestimated the impact the nine new case-mix groups would have on aggregate payments. To ensure that the implementation of the nine case-mix groups does not continue to increase payments, CMS proposes to revise the parity adjustment. Because the new case-mix groups only affect the nursing weights, CMS plans to apply the parity adjustment to the nursing component of the daily payments.

The Commission agrees that CMS should revise the parity adjustment to reflect more recent information about the impact of these changes on payments. Ideally, this adjustment would be applied to the base payments to make it consistent with similar adjustments in other PPSs. However, we understand that CMS does not have the authority to adjust the nursing base rates and instead has adjusted the relative weights. CMS should seek authority to make this adjustment to the base rates and the Commission will highlight the need for such CMS authority as it deliberates and advises the Congress on SNF payment policy over the coming year.

Parity adjustment for 2011*:* CMS estimates that the introduction of the RUG-IV classification system will lower aggregate payments and proposes to apply the necessary parity adjustment to the nursing component. Because the adjustment is applied only to the nursing component, there is a substantial shift in dollars from the therapy component to the nursing component.

The Commission agrees that CMS should make a parity adjustment in FY 2011 so that changes to the case-mix system do not by themselves raise or lower payments. Because the proposed changes for 2011 affect both the nursing and therapy components, ideally the parity adjustments should be applied separately to each component. However, CMS does not have the authority to adjust the therapy base payments to reflect current therapy costs. With the expanded use of concurrent therapy, the inflation-adjusted costs to furnish therapy have declined since the PPS was first implemented. If CMS applied the parity adjustment to the therapy component, it would lower the therapy dollars by recognizing the costs of concurrent therapy but then increase spending back up to current levels through the parity adjustment. As a result, therapy spending would remain well above therapy costs.

By applying the parity adjustment to only the nursing component, CMS used the only lever it has to shift spending away from therapy services and towards nursing services. The Commission has previously noted that such redirection is necessary to avoid overpaying for therapy services and to more accurately pay for medically complex care. The Commission believes that the therapy base rates should be lowered to reflect the increased productivity of furnishing therapy services. Because NTA services continue to be paid through the nursing component, the higher nursing payments will, indirectly, raise payments for NTA services. However, higher nursing payments will not improve their targeting until a separate component is established.

In the short term, the approach CMS has taken to maintain budget neutrality is a way to redirect spending until CMS has the authority to make the appropriate adjustments to therapy payments. CMS should seek the authority to revise the base payments so that they reflect current practice patterns and cost structures of SNFs. The Commission will highlight the need for such CMS authority as it advises the Congress on SNF payment policy over the coming year.

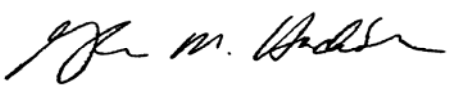
CMS notes that it may, in the future, adjust payments if it observes coding or classification changes that do not reflect real changes in case-mix. We agree that this monitoring is critical and believe that such adjustments are necessary to ensure that changes in payments reflect the resources required by patients.

Staffing data

CMS invites comments about requiring nursing homes to report nurse staffing data on a quarterly basis using payroll data and invoices. The Commission supports the gathering of these data. Requiring facilities to report these data will allow CMS to expand the quality measures it reports publicly. In addition, the data will be auditable and overcome the longstanding criticisms of the staffing data collected by the Online Survey Certification and Reporting System (OSCAR).

MedPAC appreciates the opportunity to comment on the rule. 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 Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



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