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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-1679-P**

Dear Ms. Verma:

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 2018, SNF Value-Based Purchasing Program, SNF Quality Reporting Program, Survey Team Composition, and Proposal to Correct the Performance Period for the NHSN HCP Influenza Vaccination Immunization Reporting Measure in the ESRD QIP for PY 2020" in the *Federal Register*, Vol. 82, No. 85, p. 21014 (May 4, 2017). We appreciate your staff's ongoing efforts to administer and improve the payment system for skilled nursing facilities and dialysis facilities, particularly given the many competing demands on the agency staff's resources.

The Commission's comments are organized into four sections: the proposed update, value-based purchasing, quality reporting, and ideas for future PAC projects.

**Update to the proposed rates under the SNF PPS**

The proposed rule increases Medicare's payment rates for skilled nursing facilities (SNFs) by 1 percent, as required by Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Medicare's payments to the SNF sector are estimated to increase by \$390 million during FY 2018.

*Comment*

The Commission understands that the Balanced Budget Act of 1997 requires CMS to update the SNF prospective payment system (PPS) rates and that this year's 1 percent update was mandated in MACRA. 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 determined that Medicare's current level of payments appears more than adequate to accommodate cost growth—the aggregate Medicare margin for freestanding SNFs in 2015 was 12.6 percent, the sixteenth consecutive year that it exceeded ten percent.

In its March 2017 report to the Congress, the Commission discussed its growing concerns with the lack of progress on implementing changes to PAC payments that unnecessarily raise program spending and encourage SNFs and home health agencies (HHAs) to furnish care that is not related to patient characteristics and to selectively admit some patients over others. The Commission estimates that had its payment update recommendations in 2008 for HHAs and SNFs been implemented, fee-for-service spending today would be \$11 billion lower.

The Commission began discussing the needed reforms to the SNF PPS in its June 2007 report and the following year recommended a design to base payments on patient characteristics (not the amount therapy they received) and to better target payments for nontherapy ancillary services (NTA, such as drugs). Each year since its initial recommendation, the Commission has repeated the need to lower payments to SNFs and to revise the payment system. This year, the Commission recommended that the Congress eliminate updates to the SNF payment rates for FY 2018 and FY 2019, and that CMS use this period to revise the SNF prospective payment system. Then, in FY 2020, the Secretary should report to the Congress on the impacts of the reformed PPS and make any additional adjustments to payments needed to more closely align payments with costs. In addition to lowering program payments, the recommendation would increase the equity in payments for different conditions, thereby dampening the incentive for providers to select some patients over others.

The Commission hopes that this year there will be renewed attention to reforming payments made to PAC providers, including SNFs. Given the considerable work by the Commission and others (including the Government Accountability Office, Office of Inspector General, and the Department of Justice) on the problems with this payment system, the Commission is disappointed that CMS has opted to delay the implementation of the proposed changes until FY 2019. The reason for this timing is unclear since the re-design is clearly laid out in the 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. Because FFS rates form the basis of Medicare Advantage benchmarks and a variety of current and future alternative payment models, the delay affects payments under these other programs as well.

### **Value-based purchasing for SNFs**

The Protecting Access to Medicare Act (PAMA) of 2014 requires the Secretary to implement a value-based purchasing (VBP) program for SNFs beginning in October 1, 2018. The law requires the VBP program to vary Medicare payments for SNF services using the rate of all-cause all-condition 30-day readmissions to hospitals and to replace it as soon as practicable with a potentially preventable readmission measure. CMS states that the earliest the replacement measure can be implemented is FY 2021. In assessing SNF performance, the Secretary is required to rank each facility's performance (i.e., on their readmission rates) and consider the higher of a SNF's improvement or attainment.

CMS has been reviewing reports prepared by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academies of Sciences, Engineering, and Medicine on the issue of accounting for social risk factors in CMS's value-based purchasing and quality reporting programs, and considering options on how to address the issue in these programs. CMS has also been monitoring and awaiting the results from the National Quality Forum's 2-year trial period on risk adjustment for quality measures. CMS is soliciting comments on how and whether to consider social risk factors in assessing a provider's performance. Further, it seeks comments on how to tie performance to payment for providers whose actual performance is better than the risk-standardized rate.

*Comment*

The Commission supports VBP policies as a way to encourage providers to furnish high-value care to Medicare beneficiaries. Although PAMA specifies a single performance measure (a readmission measure), the Commission urges CMS to seek the authority to broaden the scope of the VBP policy to include other post-acute care outcome measures. The Commission supports the transition to a potentially preventable measure as soon as CMS deems it practicable, but notes that both measures could be improved. By counting readmissions during the first 30 days after discharge from the hospital, both measures will miss readmissions that occur later during the SNF stay. Because SNF stays often exceed 30 days (about one-third of stays are longer than this), using this definition will relieve SNFs of the responsibility for beneficiaries who have a readmission after the 30 days but who are still patients in the SNF. In addition, the current definition could create incentives for SNFs to delay needed hospital care until after the 30<sup>th</sup> day to avoid including the readmission in their performance measure. Further, the current definition does not hold all SNFs accountable for readmissions during a fixed period of time after discharge to encourage safe transitions to the next setting (or home). Relatively short stays (those under 30 days) will have readmissions that occur during the remaining days (that will vary by stay) count in the measure. Instead, the Commission supports measures that hold providers accountable for the *entire* period of time the patient is under the SNF's care *and* for a set period of time after discharge. The Commission encourages CMS to rethink its readmission measures to meet both of these objectives.

In December 2016, ASPE identified three policy solutions to account for social risk factors: include the factors in the risk adjustment; exclude the social factors from risk adjustment but stratify providers into groups by the factor of interest (such as the share of low-income patients); or create a separate payment adjuster. MedPAC has supported the second option, using peer groups, because it is straightforward to implement, does not minimize incentives to improve for providers with high shares of beneficiaries with social risk factors, and does not "mask" provider performance. Instead, providers would compare their unmasked performance (the rates would have still been adjusted for differences in patient age, sex, and comorbidities) with providers with similar social risk factors. For example, risk-adjusted readmissions would be compared for providers with similar shares of low-income patients. CMS can then consider how to tie this performance to payment.

One anomaly of the risk-adjustment approach taken by CMS is that a provider with zero readmissions could end up with a risk-standardized rate that is non-zero. Its reported performance would be worse than it was and the provider could be penalized for a performance that met the objectives of the policy (zero readmissions). This occurs, especially for low-volume providers, because of the statistical approach taken to address the random variation in outcomes. For SNFs with unusually high or low rates (typically small providers), CMS effectively blends the provider's own rate with the national average rate. This technique is referred to as "shrinkage" because it shrinks all variation towards the mean. The rates for providers with unusually high or low performance are adjusted closer to the national average, thereby "improving" the rate for exceptionally poor performers and "worsening" the rate for unusually good performers. This approach hides the true differences in performance and may dampen a SNF's incentive to improve because its score only partially depends on its own performance.

In its June 2013 report to the Congress, the Commission outlined a preferred approach to dealing with providers with low numbers of readmissions—expand the years included in the performance period so that low volume providers have sufficient volume to avoid unusually high or low performance that results from random variation. This would be similar to the revisions CMS may consider to expand the performance periods for the 30-day post-discharge readmission and community discharge measures. While this alternative includes older performance in the measure (and therefore may be considered less preferable), it includes only the provider's own performance in the measure calculation. As such, it is a truer reflection of the provider's actual performance.

### **Quality and resource use reporting**

The IMPACT Act of 2014 requires the collection of uniform patient assessment information and the implementation of standardized quality and resource use measures. This year, CMS proposes to: revise two measures (the rate of readmission within 30 days of discharge from the SNF and the rate of discharge to community); define standardized patient assessment items; and define five new quality measures (self care at discharge, mobility at discharge, changes in self care, changes in mobility, and changes in skin integrity).

#### *Comment*

CMS proposes to expand the performance periods for the 30-day post-discharge readmission and community discharge measures to avoid the need to drop low-volume providers from public reporting. The Commission supports this revision. Ideally, all providers would have sufficient volume to avoid including relatively "old" performance that may not reflect current performance. However, because some providers do not have sufficient volume and it is important to include as many providers as possible in the public reporting, the expansion to include older performance is a good solution.

The Commission has several comments about the proposed quality measures. The measures of changes are intended to capture patients who are expected to improve during the course of the stay. CMS plans to exclude patients with certain conditions who are not expected to improve and

patients who are already independent (and cannot improve). The Commission encourages CMS to develop future measures that will gauge how well a provider maintains patient function. This will hold providers accountable for preventing the deterioration of patient function. The Commission notes it will be important to monitor the accuracy of the function data, both at admission and at discharge. Especially if the data are tied to payment, providers will have an incentive to record a patient's function lower than it is at admission and to record it higher than it is at discharge. Last, the definition of "at admission" needs to be consistent so that a patient's function is captured at reasonably similar points in time. This will allow for fair comparisons across patients in SNFs and in other PAC settings. Particularly problematic in this regard is the first assessment for SNF patients (the Day-5 assessment), which can be conducted between Day 1 and Day 8. While the Commission appreciates that providers need some flexibility in when staff conduct the first assessment, requiring that the assessment be completed within 3 days of admission would give them ample time to complete this activity.

The Commission supports the addition of elements to the PAC assessment tools that are standardized across the PAC settings. However, CMS needs to be mindful that measures, when used for risk-adjustment, may be susceptible to inappropriate manipulation by providers. Of the items included in the proposed rule, the Commission is concerned about the inclusion of assessment items that may induce service use, such as oxygen therapy, intravenous medications, and nutritional approaches. The Commission supports the inclusion of these care items when they are tied to medical necessity. For example, in prior Commission work developing a reformed payment system for SNFs, we required that patients be counted as using oxygen services only if they have diagnoses that typically require the use of oxygen. We encourage CMS to take a similar approach in measuring use of services that are discretionary. For some elements, CMS may want to 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. Items that were not proposed but may warrant consideration include cardiac monitoring and specialty bed/surfaces, both high-cost services. Because patient assessment items are sometimes considered in a risk adjustment approach, CMS may want to examine whether future collection efforts should include these services.

CMS requested input on whether it should require providers to collect quality data for all SNF patients, not just Medicare beneficiaries. This information would have clear benefits: enabling comparisons between FFS beneficiaries and other users (including beneficiaries enrolled in Medicare Advantage), and informing beneficiaries about the broader quality of the entire facility, especially those who are or will become long-term care residents of the same facility. We have heard from some providers that sorting out which patients require assessments is almost as much work as completing the assessment, so they currently assess all patients. That said, all data collection incurs some cost. The Commission supports the collection if it is deemed by providers as not overly burdensome.

Finally, CMS invited comment on possible future quality measures, including: measuring pain, the percent of residents assessed and given a seasonal influenza vaccine, and measuring patients

who received an antipsychotic medication. While these measures capture important dimensions of SNF care, the Commission prefers that Medicare hold providers accountable for claims-based outcome measures. This does not preclude providers from using these quality measures for their own quality improvement activities.

### **Ideas for future CMMI work and CMS efficiencies**

CMS solicited ideas for models to test ways to manage, deliver, and pay for care to beneficiaries. Over many years, the Commission has supported payment reforms that consider comprehensive approaches to paying for the entire episode of care for beneficiaries. Such approaches would encourage coordination across providers while giving providers flexibility in how best to manage the care, leading to successful outcomes. To that end, the Commission has submitted its ideas and comments on accountable care organizations (ACOs) and bundled payments, many of which CMS has adopted.

The Commission sees a role for bundled payments around individual conditions, especially those that can be defined narrowly and have a limited set of expected clinical pathways. Such conditions simplify defining when a bundle is initiated, establishing benchmarks, and attributing the episode to a specific provider. Further, conditions that typically require a moderate amount of PAC services will afford providers ample opportunities to improve care and lower spending. The Commission has also discussed its concerns about how these bundled payments intersect with broader reform models that require an entity to assume greater risk for an entire population, such as ACOs. When multiple models overlap, the attribution rules determine which providers are “credited” with changes, which may not always align with where the changes in practice occurred.

The Commission is also worried about the generalizability of some of the results produced by CMMI’s initiatives. The CMMI is testing a wide array of models allowing for a wide mix of conditions (and the flexibility to discontinue participation), size of entity, length of duration, and method of payment. While we see a role for these models, the very nature of voluntary participation will undermine the generalizability and scalability of these results. For these reasons, the Commission encourages CMS to remain open to mandatory models for carefully considered designs.

CMS also solicited ideas about changes that would improve the quality of care and lower the costs of the health care delivery system. Last year, under direction from the Congress, the Commission proposed features of a PAC PPS to span the four PAC settings—home health agencies (HHAs), SNFs, inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). This year it recommended that a PAC PPS begin to be implemented in 2021 and at that time CMS begin to align the regulatory requirements across the four settings. The implementation of a PAC PPS would streamline the administration of four separate payment systems to one, thereby simplifying CMS’s operations. Likewise, consolidating the conditions of participation would reduce CMS’s burden from administering four setting-specific requirements to managing one set. Finally, a common PPS would greatly increase the equity of the HHA and SNF PPSs for patients and providers.

Seema Verma, MPH  
Administrator  
Page 7

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 at (202) 220-3700.

Sincerely,

A handwritten signature in black ink that reads "Francis J. Crosson MD." The signature is written in a cursive, flowing style.

Francis J. Crosson, MD  
Chairman