MEDPAC Medicare Payment Advisory Commission

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June 3, 2013

Marilyn Tavenner, 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-1545-P

Dear Ms. Tavenner:

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 2014, *Federal Register*, Vol. 78, No. 87, p. 26438 (May 6, 2013). 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 increases Medicare's payment rates for skilled nursing facilities (SNF) by 1.4 percent, reflecting a market basket increase of 2.3 percent, a 0.5 percent reduction for a forecast error correction, and a 0.4 percent reduction for productivity adjustment as required by the Patient Protection and Affordable Care Act (PPACA). On net, Medicare's payments to the SNF sector are estimated to increase $500 million in FY 2014. While we understand that CMS is required by law to update the SNF PPS payment rates, we note that after reviewing many factors—including indicators of beneficiary access, the volume of services, the supply of providers, and access to capital—Medicare's payments appear more than adequate even at current levels before any update. We estimated the aggregate Medicare margin for freestanding skilled nursing facilities (SNF) in 2011 ranged from 22 percent to 24 percent, the eleventh year in a row that it exceeded ten percent. The Commission concluded that SNF payments are more than adequate to accommodate cost growth and in March 2013 reiterated its previous recommendation to eliminate the market basket update, revise the prospective payment system (see below), and rebase payments beginning with a 4 percent reduction.

MedPAC's key concern with the proposed rule is that it does not correct two well-established shortcomings of the current design of the SNF PPS. First, payments for nontherapy ancillary (NTA) services (such as drugs) continue to be tied to nursing services even though NTA costs do not necessarily vary with nursing time and are much more variable. Second, payments for therapy services encourage providers to furnish these services for financial, rather than clinical reasons.

The monitoring information included in the proposed rule underscores the persistent trends in therapy provision: the increasing share of days classified into therapy case-mix groups, and within those, into the highest-therapy groups.

In 2008, the Commission recommended revising the SNF PPS by creating separate prospective payment components for nursing and NTA services based on patient characteristics, not the amount of therapy provided. Compared with policies in place, the proposed design would result in more accurate payments for NTA services and payments for therapy services that would remove the incentive to furnish these services for financial reasons. The recommended changes would shift payments away from facilities that treat highly-profitable rehabilitation patients, and towards medically complex patients, and the facilities that treat them.

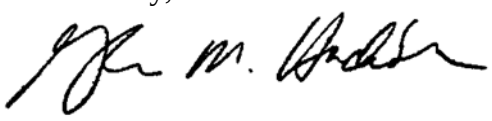
Since its recommendation to revise the PPS in 2008, the Commission has updated its PPS design work in three ways. First, it compared its recommended design with a more current permutation of the SNF PPS (2012) and found that despite the many changes CMS has made to the PPS, a revised design would still improve the accuracy of payments. Second, when CMS laid out criteria for a redesign of the NTA component of the PPS subsequent to MedPAC's recommendation, the Commission developed alternate approaches to the NTA component that retained most of their ability to predict NTA costs. Last, the Commission examined a therapy component design that would establish therapy payments for the entire stay. We found that while stay-based designs are likely to be less accurate, they are not substantially so, and they have the added benefit of dampening the incentive to extend stays unnecessarily as a way to generate revenue.

The Commission urges CMS to move forward now with a revised PPS design. At this point, the shortcomings are well known, the trends in service use indicate that the refinements have not corrected them, and solutions are at hand. Once the deficiencies in the current PPS are corrected to eliminate inappropriate payment incentives that favor some types of patients and practice patterns over others, policymakers will have a more accurate assessment of the sector's financial performance under Medicare. CMS can then proceed with the much-needed rebasing of the payment system signaled by the sector's extremely high Medicare profit margins. Given the acute financial pressures facing the Medicare program, the Commission asserts there is an urgent need to revise the SNF PPS and rebase payments.

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,



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