MEDPAC | Medicare Payment Advisory Commission

425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • www.medpac.gov

Michael E. Chernew, Ph.D., Chair
Amol Navathe, M.D., Ph.D., Vice Chair
Paul B. Masi, M.P.P., Executive Director

May 28, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS-1802-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2025" in the *Federal Register*, vol. 89 no. 65, p. 23424 (April 3, 2024). We appreciate CMS's ongoing efforts to administer and improve the payment system for skilled nursing facilities (SNFs), particularly given the many competing demands on the agency's staff.

Our comments focus on four issues:

- The proposed update to the fiscal year (FY) 2025 SNF payment rates,
- The proposed changes to the SNF wage index,
- CMS's request for input about the SNF Quality Reporting Program; and
- CMS's request for input about the SNF Value-Based Purchasing Program.

Market basket update factor for FY 2025, forecast error adjustment, and productivity adjustment

CMS proposes to increase the SNF payment rates by 4.1 percent. This reflects a 2.8 percent SNF market basket update minus a 0.4 percentage point total factor productivity adjustment (both required by law), plus a 1.7 percentage point forecast error adjustment. Since 2003, CMS has adjusted the market basket percentage update to reflect forecast error if the difference between the forecasted and actual change in the market basket exceeds a specified threshold (0.5 percentage point). At the time of the final rule for FY 2023, using the most recently available forecasted data, CMS finalized an increase in the SNF market basket of 3.9 percentage points. Since updated data indicate that the actual

market basket increase was 5.6 percentage points, CMS proposes to increase the market basket update for FY 2025 by 1.7 percentage points.

Comment

The Commission understands that by law CMS is required to update the SNF prospective payment system (PPS) rates by the market basket minus a productivity adjustment. However, we note that after assessing indicators of Medicare's fee-for-service (FFS) payments to SNFs—including beneficiary access to SNF care and SNFs' aggregate Medicare margins—the Commission recommended in its March 2024 report that the Congress reduce the 2024 Medicare base payment rates by 3 percent for FY 2025.[1] Not including federal relief funds, the aggregate FFS Medicare margin for freestanding SNFs in 2022 was over 18 percent, the 23rd consecutive year that this margin has exceeded 10 percent. The high margins indicate that a reduction is needed to more closely align aggregate payments to aggregate costs.

Although CMS is required by statute to update the payment rates each year by the estimated change in the market basket, the agency is not required to make automatic forecast error corrections. Consistent with the Commission's comments on prior proposed rules (for FY 2008, FY 2022, FY 2023, and FY 2024) we do not support forecast error adjustments for three reasons. First, in some years, such as the one addressed by the proposed rule for FY 2025, the forecast error correction results in making a larger payment increase in addition to the statutory update, even as the aggregate FFS Medicare margin is high. Second, the adjustments result in more variable updates than had no adjustment been made. Since FY 2004, when CMS implemented the adjustment, forecast error corrections have ranged from a 3.26 percent increase (in FY 2004) to a –0.8 percent reduction (in FY 2022).[2] Eliminating the adjustment for forecast errors would result in more stable updates. Third, the adjustment results in inconsistent approaches to updates across settings: Except for the updates to the capital payments to acute care hospitals, CMS does not apply forecast error adjustments to any other market basket updates.

Wage index adjustment

Since the start of the SNF PPS, CMS has used general acute care hospital wage data to develop the SNF PPS wage index. For FY 2025, CMS proposes to continue to use the unadjusted inpatient prospective payment systems (IPPS) wage index (referred to as the "pre-floor, pre-reclassification hospital inpatient wage index"). CMS proposes to: (1) update the SNF wage indexes with newer wage data and Office of Management and Budget

[1] Medicare Payment Advisory Commission. 2024. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC
[2] CMS makes a forecast error adjustment whenever the difference between the forecasted and actual percentage increase in the market basket exceeds 0.5 percentage point (a 0.25 percentage point difference was used between FY 2004 and FY 2007, but the threshold was raised to 0.5 percentage point in FY 2008).

(OMB) delineations, and (2) continue its policy of capping the wage index decrease a provider can experience in a given year at 5 percent.

Comment

The Commission supports CMS's annual process to update the SNF PPS wage index with newer wage data and OMB delineations. The Commission also supports having a policy to cap the wage index changes that a provider can experience in a given year (though we have previously stated that the maximum change should apply to annual increases as well as decreases).

However, the Commission has long been concerned with flaws in the wage index system that Medicare uses to adjust SNF payments to reflect geographic differences in labor costs.[3] To improve the accuracy and equity of Medicare's wage index systems for IPPS hospitals and other providers (such as SNFs), Medicare needs wage indexes that are less manipulable, more accurately and precisely reflect geographic differences in market-wide labor costs, and limit how much wage index values can differ among providers that are competing for the same pool of labor. In the Commission's June 2023 report to the Congress, we recommended that the Congress repeal the existing Medicare wage index statutes, including current exceptions, and require the Secretary to phase in new wage index systems for hospitals and other types of providers that:

- use all-employer, occupation-level wage data with different occupation weights for the wage index of each provider type,
- reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas, and
- smooth wage index differences across adjacent local areas.[4]

Skilled Nursing Facility Quality Reporting Program (SNF QRP)

CMS seeks input on future measure concepts for the SNF QRP to guide its measure development efforts. The measure concepts include immunization status of residents, pain management, depression, and patient experience/satisfaction of care.

Comment

The Commission supports the development of a measure of patient experience. Patient experience is a key measure of a provider's quality. Patients who feel heard and have positive care experiences have better health outcomes and are more likely to adhere to

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[3] Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare.* Washington, DC: MedPAC
[4] Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC

treatment plans. Although the Department of Health and Human Services and industry organizations have developed initial surveys to capture patient experience information, the Secretary has not finalized a patient survey and data collection process. In June 2021, the Commission recommended that the Secretary finalize development of and begin to report patient experience measures for SNFs.[5]

Validation process for assessment data used in the QRP

The Consolidated Appropriations Act, 2021, requires the Secretary to validate data submitted under the SNF QRP, including data included on claims and in the patient assessment (the Minimum Data Set, or MDS). CMS proposes to adopt a process similar to that used to validate information for the VBP. In FY 2024, CMS finalized its approach to validating the MDS information used in the VBP—randomly selecting up to 1,500 SNFs on an annual basis and requesting up to 10 randomly selected medical records from each. CMS proposes to use the same process to validate the MDS data used in the QRP. To decrease the reporting burden on providers, the same records would be used for both purposes. For providers that do not submit the requested information within the specified timeframe, CMS proposes to lower the market basket update by 2 percentage points for the fiscal year two years after the record request.

Comment

The Commission supports the implementation of a validation process. For years, the Commission has raised concerns about the accuracy of the self-reported MDS information, especially for data elements used in quality reporting and/or to establish payments.[6] To encourage accurate reporting of information, the Commission also supports validating the data for a meaningful share of providers and urges CMS to request information from the full 1,500 providers and the 10 records from each provider each year, rather than fewer providers and fewer records.

Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP): Proposed policy changes

Future measures

By statute, the Secretary may include up to 10 measures in the VBP (one must be readmissions). After the phasing in of new measures, the program in FY 2028 will include eight measures—within-stay readmissions, infections that require hospitalization, total nursing hours per resident day, total nursing staff turnover, discharge to community, falls with major injury, discharge function score, and long-stay hospitalizations. CMS is

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[5] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, DC: MedPAC
[6] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, DC: MedPAC

considering future revisions to the measure set, including the addition of a measure of patient experience and combining the two staffing measures into a composite measure.

Comment

While the Commission supports limiting the VBP to a small number of measures, we support adding a measure of patient experience. Patient experience is a key measure of a provider's quality and adding this measure to the VBP would fill a gap in the current measure set. In its comment letter in 2022, the Commission previously stated that it does not support the inclusion of the *Discharge Function Score* and *Percent of Long-Stay Residents Experiencing One or More Falls with Major Injury* measures in the SNF VBP.[7] Although these are critically important aspects of quality, due to concerns about the accuracy of MDS data, we continue to caution against VBP measures—including incidence of falls and change in or attainment of function—based on provider-reported MDS assessment data at this time. In the future, when the MDS data are validated with the proposed validation process, the accuracy of this information is likely to improve. Regarding the development of a composite staffing measure, the Commission supports retaining the two staffing measures in the VBP because they gauge different and complementary dimensions of a facility's quality. While staffing levels measure the amount of direct care provided to residents, a turnover measure indicates the continuity of care in a facility. Depending on the design, a composite measure could reduce the contribution of staffing in assessing a provider's performance.

Proposed measure minimum policies

CMS proposes to adopt the FY 2027 case minimum for FY 2028. SNFs must report the minimum number of cases for four of the eight measures that will be included in that year's measure set. SNFs that do not meet this measure minimum requirement will be excluded from the VBP.

Comment

Minimum stay counts help ensure that measure results are reliable—that is, they distinguish performance across providers. When measures are unreliable, the performance of one provider may appear to be different from another provider when in fact the sampling error around the estimate is so large that their performances are not statistically different from each other. Especially when tied to payment, measures should accurately reflect performance, not random variation.

The Commission is concerned that the VBP may reward and penalize random variation, not actual performance for some providers, especially those with small case counts. In its June 2021 report, the Commission identified the minimum counts CMS uses to ensure reliable measures as a key shortcoming of the current design. Unfortunately, CMS has not

[7] https://www.medpac.gov/wp-content/uploads/2022/06/06082022_SNF_FY2023_MedPAC_COMMENT_SEC.pdf

corrected this flaw, although it has the authority to do so. The minimum counts currently used are too low to ensure reliable measures. The Commission urges CMS to increase the minimum counts to a level that is sufficient to meet a commonly used standard of reliability (0.7, meaning 70 percent of the variation is explained by differences in performance and 30 percent is attributed to random chance).[8] In our work, we found that minimum counts of 60 were needed for reliable results for the measures we included in our SNF value incentive program design (readmissions, successful discharge to the community, and Medicare spending per beneficiary).

The Commission appreciates that there is a tradeoff between achieving reliable results and driving quality improvement in as many providers as possible. One way to expand the number of SNFs meeting this higher reliability standard is to include multiple years in the performance period. More recent years could be weighted more heavily than earlier years. We urge CMS to consider tallying volume over multiple years to include as many providers in the VBP as possible. In our work, pooling data over three years resulted in the exclusion of only 10 percent of providers.[9]

Conclusion

We appreciate the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. The Commission 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 Paul Masi, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

Michael E. Chernew, Ph.D.
Chair

[8] See for example: Adams, J. L., A. Mehrotra, J. W. Thomas, et al. 2010. Physician cost profiling—Reliability and risk of misclassification. *New England Journal of Medicine* 362, no. 11 (March 18): 1014–1021; Kao, L. S., A. A. Ghaferi, C. Y. Ko, et al. 2011. Reliability of superficial surgical site infections as a hospital quality measure. *Journal of the American College of Surgeons* 213, no. 2 (August): 231–235; Krell, R. W., A. Hozain, L. S. Kao, et al. 2014. Reliability of risk-adjusted outcomes for profiling hospital surgical quality. *JAMA Surgery* 149, no. 5 (May): 467-474; Mehrotra, A., J. L. Adams, J. W. Thomas, et al. 2010. Cost profiles: Should the focus be on individual physicians or physician groups? *Health Affairs* 29, no. 8 (August): 1532–1538; and Scholle, S. H., J. Roski, J. L. Adams, et al. 2008. Benchmarking physician performance: Reliability of individual and composite measures. *American Journal of Managed Care* 14, no. 12 (December): 833–838.

[9] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery System.* Washington, DC: MedPAC