601 New Jersey Avenue, N.W. • Suite 9000
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman
Robert A. Berenson, M.D., F.A.C.P., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

July 29, 2010

Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1338–NC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: File code CMS-1338-NC

Dear Dr. Berwick:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Center for Medicare and Medicaid Services (CMS) proposed rule entitled Medicare Program; Prospective payment system and consolidated billing for skilled nursing facilities for FY 2011, published in the *Federal Register*, vol. 75, no. 140, pages 42886 to 42942. We appreciate your staff's ongoing efforts to administer and improve payment systems for skilled nursing facilities (SNF), particularly considering the agency's competing demands. This notice updates the payment rates for SNFs for FY 2011.

The law requires CMS to update rates annually; for 2011 CMS has proposed an update of 1.7 percent. 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. In 2008, the aggregate Medicare margin for freestanding SNFs was 16.5 percent. The Commission concluded that SNF payments are more than adequate to accommodate cost growth and in March 2010 recommended to the Congress that the industry receive no payment update for fiscal year 2011.

The Commission would like to use the opportunity to comment on this notice to emphasize concerns we have raised with CMS before: the need to change the way nontherapy ancillary (NTA) and therapy services are paid and the consideration of group therapy minutes in assigning beneficiaries to case-mix groups.

Paying for nontherapy ancillary and therapy services

The Commission remains concerned that CMS has yet to correct two well-known problems with the prospective payment system (PPS) for skilled nursing facilities (SNF) that affect payments for nontherapy ancillary (NTA) services (such as drugs and respiratory care) and therapy services. For many years, the Commission has highlighted these shortcomings of the PPS design and urged CMS to correct them.

In the case of NTA services, the implementation of the new case-mix system is unlikely to fully correct the inaccuracies that result from tying NTA payments to the nursing component of the daily rate. The new case-mix classification system has more groups and therefore is likely to lower the variation in nursing costs across the patients within any given group. However, payments for NTA services continue to be tied to nursing time even though NTA costs have historically varied much more than nursing costs and did not vary with them. As nursing costs increased, NTA costs did not necessary increase and, if they did, they did not necessarily increase at the same rate. Consider two patients in the same case-mix group who require identical nursing care but one is taking an expensive drug. A facility will be paid the same for these two patients, even though it would incur higher NTA costs for one of the patients. In 2008, the Commission recommended that CMS establish a separate payment component to pay for NTA services based on patient care needs.

In the case of therapy services, the Commission remains concerned that providers will continue to have a financial incentive to furnish therapy services because the new case-mix system does not change the fee-for-services nature of the therapy component of the PPS. This component could induce providers to increase the amount of therapy they provide for financial, rather than clinical, reasons. This year, CMS plans to change the assignment of patients to case-mix groups, using allocated time for patients who receive concurrent therapy.[a] This allocation will improve the accuracy of payments for these patients. But regardless of the therapy modality (group, concurrent, or individual), payments remain driven by the provision of services, rather than a patient's care needs.[b] In 2008, the Commission recommended that the therapy component of the daily rate be based on predicted care needs, not service provision.

Consideration of group therapy

Payments for different modalities of therapy (concurrent, group, and individual) should reflect the differing costs to produce the services. Otherwise, providers will have financial incentives to furnish one modality over another, regardless of whether the modality is the most clinically appropriate for the patient.

---

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

The costs to furnish therapy services are considerably different when a patient receives individual, concurrent, or group therapy. Although a patient may spend an hour in rehabilitation, the cost to produce the hour depends on how many patients are treated at the same time. Group therapy is the least costly to furnish (because the costs are allocated to up to 4 patients), concurrent therapy is less costly (two patients can be treated at the same time), while individual therapy is the most costly because only one patient is treated by the therapist at once.

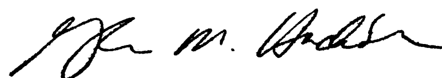
Beginning in FY 2011, CMS will allocate the therapist's time (and costs) in assigning patients to case-mix groups and establishing payment for concurrent therapy; however, CMS does not plan to allocate the times (and costs) for group therapy services. In a letter to CMS in May 2010, the Commission discussed the need to similarly allocate the therapy time for group therapy so that payments and costs are aligned for this modality. Without this correction, payments for group therapy services will be substantially higher than providers' costs and providers will have an incentive to furnish therapy using this modality. We plan to monitor the provision of the various therapy modalities to assess provider responses to the new rules for assigning patients to rehabilitation case-mix groups.

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/aj