MEDPAC Medicare Payment Advisory Commission

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
Jack C. Ebeler, M.P.A., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

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Charlene Frizzera
Acting 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: Revising the SNF Prospective Payment System

Dear Ms. Frizzera:

Last summer, we recommended to the Congress that the prospective payment system (PPS) for skilled nursing facilities (SNF) be changed to correct important shortcomings of the current design. CMS staff raised several questions about the recommended design and the models we tested. We take this opportunity to clarify our recommended design and urge you to consider it as you prepare the fiscal year 2010 proposed rule for SNF services.

The shortcomings of the current SNF PPS are extensive and create inequities for beneficiaries and providers. The PPS poorly targets payments for nontherapy ancillary services (NTA), such as intravenous medications and respiratory care, so that patients who require these services are harder to place than other patients and the SNFs that treat them are financially disadvantaged. The current design overpays for rehabilitation therapy services and relatively underpays for medically complex care. In addition, the lack of proportionality between payments and costs for therapy services creates financial incentives to furnish care that may be of marginal benefit to the patient and results in facilities selecting certain patients over others. These design flaws are partly responsible for the widely varying financial performance between nonprofit and for-profit SNFs and between freestanding and hospital-based SNFs. The Commission believes these glaring problems create an urgent need for reform and warrant correction.

The Commission's recommended design establishes a separate payment for nontherapy ancillary services, replaces the existing therapy component with one that bases therapy payments on a patient's predicted need for these services, and adds an outlier policy for

SNF stays with exceptionally high ancillary costs. The proposal increases the accuracy of payments for NTA and therapy services, dampens the incentive to furnish unneeded therapy services, and offers financial protection for patients with exceptionally high ancillary costs and the SNFs that treat them. The best design we tested did not require CMS to collect any new data but would require the agency to make changes to its current operations similar to those it undertakes when implementing or revising a PPS.

The remainder of this letter discusses the comments raised about the proposed design, organized by payment component. A section at the end addresses comments CMS raised about the models that could be used to establish payments for NTA and therapy services.

A separate component would improve the targeting of payments for NTA services

One basic problem with the current SNF PPS is that payments for NTA services are tied to nursing time, yet NTA costs have little relationship with nursing time and are much more variable. Facilities with a more costly-than-average NTA case mix (for example, patients requiring expensive antibiotics, ventilator care, and intravenous medications) are relatively underpaid for their NTA services, whereas facilities with a below-average NTA case mix are overpaid. Hospital administrators we interviewed told us that patients who require these services can be hard to place. We also found that between 2002 and 2006, the number of SNFs that treated medically complex patients (those in the special care and clinically complex case mix groups) declined more than 10 percent.

The Commission's recommended design creates a separate payment component for NTA services using patient and stay characteristics to predict NTA costs for a stay (for a complete discussion of the proposed design see MedPAC's June 2008 report, *Reforming the delivery system,* chapter 7*).* The design we tested would greatly improve the PPS's ability to predict NTA costs and result in much more accurate payments. Payments would also be much more proportional to costs, thereby decreasing the financial incentive to selectively admit certain types of patients. With the design we tested, payments would be redistributed from facilities with low NTA costs (and low shares of the patients who need these services) to facilities with high NTA costs (and high shares of the patients who need these services).

To further improve the accuracy of payments, CMS must be able to distinguish between services furnished by the SNF from those provided during the preceding hospital stay. The Commission previously recommended that services furnished since admission be recorded separately in the patient assessment instrument. Without this distinction, SNFs can receive higher payments for services they did not furnish and the program pays twice for these hospital-furnished services—once in the hospital and again in the SNF. It is possible that patients who receive certain services during their hospital stay continue to be more expensive to treat in the SNF. The data you collected in the STRIVE project can assess if this is true and revise the PPS accordingly.

A revised therapy component would dampen the incentives to furnish therapy services to boost payments

Another basic problem with the current PPS design is that it encourages facilities to furnish therapy services for financial rather than clinical reasons. Therapy payments increase as more therapy services are furnished, but the payments are not proportional to the higher costs of the additional services. Days with high amounts of therapy are relatively overpaid compared to days with low or no therapy care. The lack of proportionality between payments and costs creates an incentive to qualify days into rehabilitation case-mix groups and, within those, into the highest groups. As a result, the share of SNF days grouped into rehabilitation case-mix groups and the intensity of the therapy furnished have steadily increased. Based on data from 2002 through 2006, our analysis suggests that changes in the characteristics of the patients coming into SNFs do not explain the service growth.

To reverse these trends, the Commission has recommended that therapy payments be based on a patient's care needs, not on the amount of therapy services provided. Under such a design, payments would be higher for patients with high predicted therapy care needs (such as patients recovering from a hip fracture or a stroke) and lower for patients with low therapy care needs (such as patients with cancer or HIV). We examined designs that raise and lower payments based on many patient characteristics—including age, physical and mental status, comorbidities, and ability to perform activities of daily living —and features of the stay (such as the length of the stay). We found that a predictive therapy component could establish therapy payments that are much more proportional to services, thereby dampening the incentive to furnish these services for financial gain. We urge CMS to incorporate therapy component that establishes payments based on a patient's predicted care needs, not on the services furnished.

As with any prospectively set payment, facilities will have a financial incentive to under-furnish therapy services because SNFs will be paid the predicted amount, whether or not they provide services. The Commission outlined two ways to lower the risk of stinting.

1) CMS could tie a withheld portion of a facility's payments to risk-adjusted quality measures, such as changes in functional status and rates of community discharge and rehospitalization. Under-provision would be likely to result in poor performance on quality measures and facilities would, thereby, forfeit the withheld portion of the payment. Adequate risk adjustment and sufficient funds at stake will increase the chances that a pay-for-performance program would be successful. Measures that assess changes in a patient's condition (such as the cognitive and functional status) will require SNFs to complete patient assessments at admission and discharge , as recommended by the Commission last year.

2) The PPS could include a low utilization payment adjustment (LUPA) policy. Under a LUPA policy, payments would be lowered if the actual amount of therapy provided was considerably lower than what had been predicted. This policy could be implemented on a stay basis (payments would be cost-based if the amount of therapy furnished during a stay was considerably below the predicted amount) or on a facility basis (all payments in a subsequent year would be

lowered if a facility had exhibited a pattern of under-provision across all of its stays).

An outlier policy would defray the exceptionally high costs for some patients

The current PPS lacks an outlier policy to provide additional payments for stays with exceptionally high costs. Although the SNF PPS limits a provider's financial exposure by paying on a per day basis and by setting therapy payments based on service provision, SNFs are at risk for treating the few patients with unusually high costs. We found a small number of days with ancillary and NTA costs that were 10 times higher than their medians.

Consistent with the outlier policies of other PPSs, the recommended policy would require providers to incur a loss of a set amount and cover only part of the costs above the fixed-loss amount. Because the financial risk for a provider is determined by the losses over a stay, not on any given day, we proposed an outlier policy for large losses on a per stay basis. This is similar to the outlier policy of the psychiatric hospital PPS, another PPS that establishes payments for a day of care.

We considered an outlier policy for losses attributable to ancillary services (which include therapy care and NTA services) because our analysis found there were SNFs with exceptionally high costs for both services. Furthermore, a broad definition that encompasses ancillary and NTA services does not advantage facilities treating patients with certain care needs over others. The outlier policy we considered excludes routine costs from its definition as a way to avoid advantaging hospital-based facilities, which typically have much higher routine costs than freestanding facilities. The higher costs of hospital-based SNFs that are attributable to their mix of patients would be reflected in higher ancillary or NTA costs.

We consider the outlier policy as the third prong to the proposed reform strategy, not as a stand-alone option. An outlier policy would assist facilities that treat exceptionally high cost patients whose care needs could not have accurately predicted by the therapy and NTA components. The outlier policy should not be considered as a way to "solve" the NTA problem. Outlier policies are intended to address the exceptions, not the systematic biases of a payment system.

Predictive models can reflect the wide variation in patients

The proposed therapy and NTA components would establish payments based on the predicted care needs of patients. Just as patients do not neatly divide into a finite number of groups, under the proposed design the NTA and therapy payments are not confined to 53 amounts associated with the case-mix groups. Payments would differ for each patient, depending on their characteristics. As a result, providers will not have a financial incentive to furnish just enough care to qualify patients into the highest possible case-mix groups. Because the groups are not predetermined, there could be less strategizing about

the amounts of therapy furnished. Service amounts may begin to mirror care needs rather than the amount required to qualify patients for specific case-mix groups.

Although there would not be an established set of case-mix groups and a schedule of payments, providers would know the various factors (such as age and functional status) that raise and lower payments and by how much. For example, in the models we tested, therapy payments for a patient recovering from a stroke would be 22 percent higher than payments for other patients, all else being equal, while therapy payments for patients with dementia would be 4 percent lower. The more continuous design of these components (as opposed to a fixed set of case-mix groups) has precedent. The PPS for inpatient psychiatric hospitals has a set of adjusters (including DRG, comorbidity, age and length of stay) that increase or decrease payments for each day of care but there is not a fixed number of case-mix groups.

Some staff commented that the predictive designs lacked transparency for providers to know what their payments would be for each patient. We beg to differ with this observation. While it is true that providers could no longer control their payments (by providing more or less service), they could know their estimated payments for each beneficiary based on patient and stay characteristics. SNFs would download the case-mix "grouper" software from the claims contractor. A provider would enter a patient's relevant patient characteristics and the grouper would determine an estimated payment for the patient. This process is similar to how providers in other settings estimate their expected payments for an individual patient.

CMS staff also had specific comments about two predictors we included in the NTA and therapy designs we tested: hospital diagnoses information and length of stay.

- ***Hospital diagnoses****:* In the designs we tested, hospital diagnoses improved our ability to predict NTA and therapy costs. CMS staff noted that hospital diagnoses may not be available on a timely basis for CMS to establish payments for all patients who use SNF services. But such information should be available to SNFs for every patient they treat because it underlies good care transitions between settings. The transfer of basic information about a patient's hospital stay (such as the patient's diagnoses, the procedures furnished, and the drugs taken and those that need to be continued) is essential to formulating an appropriate SNF treatment plan and furnishing high quality of care. The Commission discussed the need for hospitals and SNFs to devise a reliable way, if one did not already exist, to transfer basic patient information between them. Faxing hospital discharge summaries to SNFs would be a simple solution.

  We acknowledge that diagnostic information from a preceding hospitalization may not provide a complete picture of a patient's chronic conditions and care needs. Factors (such as all comorbidities) relevant to post-acute care may not be consistently recorded in a hospital claim for an unrelated acute hospitalization. However, current SNF diagnosis information is inaccurate, most likely because much of it is not used for payment. If the SNF PPS experience follows that of

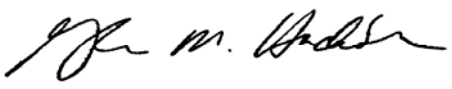
other PPSs, once diagnoses were used for payment, their completeness and accuracy would improve. The draft versions of the MDS 3.0 and the CARE tool include diagnostic information about patients at admission to a SNF that eventually could be used in the component designs. Until then, we urge CMS to use hospital diagnosis information in establishing payments for NTA and therapy services.

- ***Length of stay***: Because per day costs are lower for long stays compared to short stays, a length of stay factor helps establish accurate daily payments. However, a SNF does not know on an interim basis how long a patient's stay will be. So that providers can receive payments before the patient is discharged from the SNF, CMS could calculate interim payments on the presumption that the length of stay would be long. At discharge, CMS would then calculate what the payment should have been for the preceding payments, based on the actual length of stay. Since payments are higher for shorter stays compared to longer stays (all other factors being equal), the facility would receive additional payments for the early days in short stays and CMS would not have to recoup payments already made.

We urge CMS to use the proposed rule to correct the fundamental shortcomings of the current PPS, establish appropriate incentives for providers, and improve the accuracy of payments for all types of patients. The proposed changes should increase your ability to explain cost differences across patients so that payments are more accurate, especially for NTA services. In addition, payments should be proportional to costs, thereby dampening the incentives to furnish certain services and to selectively admit beneficiaries. Because there are large differences in the care needs across patients, the design should be evaluated separately for Medicare beneficiaries, long-stay residents, and for different types of cases.

We recognize that the Commission's recommended design will require CMS to make key changes to the current design, many of which are consistent with features of other PPSs. We believe that the existing distortions and inequities of the SNF payment system warrant such action. We hope this clarifies our design and addresses the concerns raised by CMS staff. If you have any questions about any of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,



Glenn M. Hackbarth, J.D.
Chairman

cc: Elizabeth Richter
Laurence Wilson
Sheila Lambowitz