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Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244–8016

Attention: CMS–1696–P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) Proposed Rule for FY 2019

Dear Ms. Verma:

Health Dimensions Group (HDG) is pleased to provide these comments regarding the proposed rule to replace the RUGs IV methodology with the Patient-Driven Payment Model (PDPM). HDG is a full-service consulting and facility management firm with a nationwide practice, including service to three of the top ten Conveners under Model 3 of the Bundled Payments for Care Improvement program. Our consultants have over thirty years of Medicare and Medicaid payment policy experience.

Overall Statement

In general, HDG supports the transition of SNF payment from RUGs IV to PDPM as part of a process to better position SNFs to succeed in the emerging value-based landscape. We support attempts to promote quality care through payment incentives and development of quality measures, rather than through regulatory micro-management strategies, which are often costly to implement and poorly targeted.

Relative to PDPM, we are concerned about the subgroup of SNFs with large negative impacts based on historical data and ask that CMS put mechanisms in place to ensure that those providers have adequate opportunity to change operational practices to remain solvent under the new payment system.

Our specific comments follow.

Specific Comments

Need for Concurrent Therapy Thresholds. CMS should reconsider the need for minimum thresholds for group and concurrent therapy. These thresholds were largely introduced in response to incentives embedded in the RUGs payment methodology, which would be no

longer applicable under the new payment system. CMS should provide evidence that supports demonstrably better outcomes at lower costs for SNF patients receiving individual versus group/concurrent therapy. If that is the case, then providers would be well advised to utilize individual therapy when appropriate. If there is not sufficient evidence, CMS should gather data and validate its assumptions prior to implementing a potentially unnecessary and costly regulatory requirement under the new payment system.

Consider Separate Clinical Category for Elective Major Joint Replacement of the Lower Extremity. HDG's experience with Model 3 of the Bundled Payments for Care Improvement (BPCI) program indicates very clearly that the episodic cost profile of elective joint replacements is materially different from almost every other episode type, including joint replacements as a result of fracture. While we understand that the payment system seeks to explain variation in per diem costs, we believe that the fundamental utilization difference for elective joint replacements merits a separate Clinical Category for the PT and OT components of the rate. Joint replacements as a result of a fracture could possibly be combined into the Other Ortho category. This change will help PDPM better fit in with value-based payment strategies (e.g., CJR) by separately identifying elective joint replacements in the SNF payment system.

In addition, a separate, but related, comment would be that CMS may want to consider customized Variable Per Diem Adjustments (VPDA) for the PT and OT components depending on the Clinical Category, including especially elective joint replacements (which have a shorter LOS profile).

Clarification on Interim Payment Assessment (IPA) Policy. Examples should be developed that show the various scenarios on IPAs, especially comparing and contrasting IPA policy with Significant Change in Condition assessment requirements under the MDS. In addition, CMS' regulatory relief calculations should factor in the added costs that SNFs will now incur from daily monitoring of their caseload to ascertain whether any patients currently in-house would qualify for this adjustment. In lieu of the variable IPA, one possible option to consider is an IPA based on a fixed time frame (e.g., 30 days). This would create a clear time frame for review instead of a vague standard, and should also be set far enough out from admission to factor out short-stays.

Integrate PDPM with SNF Value-Based Purchasing Adjustment (VBP). While we recognize that PDPM and SNF VBP are two separate rate methods, driven by separate statutory and regulatory policies, we believe there would be value in developing an integrated approach to payment that incentivizes SNFs to take more medically complex patients and also promotes readmission prevention. This comment is particularly applicable to the potentially preventable readmissions measure, which is coming in future years. Payment integration strategies could include payment for: telemedicine, post-discharge care coordination, and training on readmission prevention protocols, as well as refining the interrupted stay policies so that readmissions are not tacitly encouraged.

Readmissions prevention strategies in SNFs can be very effective, save the Medicare trust fund significant dollars, and improve patient experience, but many of these strategies require upfront investments in technology and staff training and should be appropriately reimbursed.

Thank you for consideration of these comments.

Sincerely,

Health Dimensions Group

Brian Ellsworth
Vice President, Public Policy and Payment Transformation