American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

June 25, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

***Re: CMS 1605-P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2015; May 6, 2014.***

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, including approximately 850 hospital-based skilled nursing facilities (SNFs), the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2015 proposed rule for the SNF prospective payment system (PPS). This letter addresses CMS's ongoing research on alternative payment methodologies for therapy services provided in SNFs.

The proposed rule discusses the April 2014 contracted research report by Acumen, LLC, *SNF Therapy Payment Models Base Year Final Summary Report*. This report identifies four potential payment concepts that could be studied as part of a broader analysis of alternatives for therapy service payment under the SNF PPS. The report also notes that Acumen will fully model two of these approaches to analyze and use as a basis for recommendations to CMS on how to improve therapy payment within the SNF PPS. The AHA supports this effort.

**As part of this research, the AHA encourages CMS and Acumen to factor in the findings and recommendations of the Medicare Payment Advisory Commission (MedPAC) related to improving the SNF PPS.** We particularly support MedPAC's recommendation to modify the SNF PPS to better account for non-therapy ancillary services (such as drugs, diagnostic X-ray tests, diagnostic laboratory tests and prosthetic devices), which are used more frequently for medically complex patients, a population that hospital-based SNFs often treat. We agree with MedPAC's recommendation to add a separate component to the SNF PPS to adjust for differences in patients' need for these services.

**The AHA also encourages CMS to give full consideration to adding a high-cost outlier payment adjustment to the SNF PPS, as recommended by MedPAC.** The SNF PPS is the only PPS among those for post-acute providers and hospitals that lacks this important feature. Generally, outlier policies help ensure access for high-cost patients by mitigating financial disincentives for treating this population. Specifically, as stated by the Urban Institute in its March 2012 report for MedPAC, an outlier policy in the SNF PPS would "help defray the cost of exceptionally high-cost stays." As such, the addition of an outlier payment adjustment to the SNF PPS would improve the linkage between payments and the resources used to treat patients. This would directly address the key failing of the SNF PPS – its over-reliance on therapy volume as a key driver of payment. While we recognize that CMS has made the determination that legislative authority would be needed for the agency to add this element to the SNF PPS, we note that we stand ready to support this important improvement for the SNF PPS.

The Acumen report also notes plans to convene a technical expert panel to provide feedback on this research effort. **We are discouraged that the proposed stakeholder categories do not include hospital-based SNFs and strongly urge CMS to ensure that the panel includes hospital-based SNF representation.** Hospital-based SNFs – many of which are in rural areas – play a unique role in the continuum of care; they treat more medically complex patients, discharge patients with a much shorter average length of stay, and use more ancillary services due to their higher acuity case mix. Specifically, MedPAC's March 2014 Report to Congress notes that "hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex patients." MedPAC also has steadily recognized the ongoing access challenges for medically complex SNF patients – especially those who do not require therapy services – and in its March 2014 report notes that the number of SNFs admitting medically complex patients decreased from 2011 to 2012. The role that hospital-based SNFs play in treating vulnerable medically complex patients reinforces the value of securing this voice in the forthcoming technical expert panel.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, feel free to contact me or Rochelle Archuleta, senior associate director of policy, at (202) 626-2320 or rarchuleta@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis & Development