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August 23, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of AMGA, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS') proposed Advanced Notice of Proposed Rule Making (ANPRM) concerning the Medicare program's Skilled Nursing Facilities' (SNF's) Prospective Payment System (PPS). (File code CMS-1686-NPRM). Our member medical groups, which provide care for approximately one in three Americans, have substantial interest in proposed payment reforms in post-acute care (PAC). Beyond improving the accuracy in SNF fee for services (FFS) payments, an improved SNF PPS promises to have favorable spillover effects in determining the success of the agency's Alternative Payment Models (APMs), particularly in determining the success of AMGA physician group participation in Accountable Care Organization (ACO) models. We also recognize a revised or redesigned SNF PPS will help CMS in its progression or transition to a PAC PPS, as required under the Improving Medicare Post-Acute Care Transformation Act (IMPACT Act) of 2014.

In its ANPRM, CMS notes the agency is seeking comments on the possibility of replacing the existing SNF PPS existing case-mix classification model, the Resource Utilization Groups, Version 4 (RUG-IV) with a new model called the Resident Classification System, Version I (RCS-I). Beyond the ANPRM discussion in the April proposed rule, we also appreciate the agency's release of a related technical report on the development of the RCS-I and the additional information CMS has posted on its website titled, "SNF PPS Payment Model Research" (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/therapyresearch.html>).

CMS estimates that changes to the SNF PPS will be net revenue neutral. Payments for the highest rehabilitation category would decrease by 9.1 percent, while payments for non-rehabilitation cases would be 44.5 percent higher.

AMGA supports reforms to the SNF PPS. As CMS is well aware, for nearly a decade, or since 2008, the Medicare Payment Advisory Commission (MedPAC) has been recommending that the PPS be revised. AMGA also agrees that the changes be net neutral.

However, based on the information CMS has provided, we are not convinced RCS-I will produce these financial results. While CMS has released a substantial amount of related information, including a 30-plus page worksheet providers can use to estimate financial impact and a related spreadsheet showing financial impact by SNF, the agency has not released information related to the logic used in determining financial impact.

Based on our reading of the ANPRM, we believe reimbursements may increase, and increase significantly, in certain cases in part because under RUG-IV co-morbid conditions do not count toward RUG scores, unless they compromise a beneficiary's functional status. It appears under RCS-I, co-morbid conditions will contribute, and at times contribute significantly, to higher reimbursement rates.

For example, a stereotypical stroke patient with several co-morbidities and Activities of Daily Living (ADLs) limitations would require more than 12 hours of therapy per week and would be classified under RUG-IV as an ultra-high rehabilitation patient or, the RUG-IV "RUC" category. Care for this patient would be reimbursed at the daily RUC rate of slightly more than \$600. Under the proposed RCS-I, this same patient would likely first be categorized as "special care high," or at approximately \$200 per day in reimbursed SNF services. Reimbursements for physical, occupational and speech therapy, and for non-therapy ancillary services likely would be added to this reimbursement rate. If this stroke patient remained under SNF care for 10 days, the SNF's reimbursement under RUG-IV would be approximately \$6,100. Under the proposed RCS-I, SNF reimbursement would be about \$8,700, or approximately 30 percent higher than under RUG-IV.

We also urge the agency to make available the SNF grouper software. CMS took similar action with the Home Health PPS Software. The SNF grouper software should be made available under similar protections that CMS implemented for the Home Health PPS. This would allow SNF providers to act as beta site testers.

As noted in our opening paragraph, if SNF reimbursements unexpectedly rise or increase over historical spending, ACO participants, or those in a bundled payment arrangement, such as the Comprehensive Care for Joint Replacement (CJR) demonstration, and other participants will be compromised in meeting their financial benchmark goal and/or their episode-based payment target prices. If this should prove true, not only will these participants lose their investments by participating in an APM, further voluntary participation will be discouraged. In addition, provider groups considering signing an APM contract will be discouraged from participation.

Thank you for your consideration of AMGA's comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at dintrocaso@amga.org or at 703.842.0774.

Sincerely,

A handwritten signature in black ink that reads "Ryan O'Connor". The signature is written in a cursive style with a large, looping initial "R".

Ryan O'Connor
Interim President and Chief Executive Officer
AMGA