June 9, 2022

ZIMMET HEALTHCARE SERVICES GROUP, LLC

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1765-P
P.O. Box 8016
Baltimore, MD 21244-8016

Zimmet Healthcare Services Group, LLC ("ZHSG") respectfully sets forth this response to the 2023 SNF PPS Proposed Rule (CMS-1765-5). This submission was prepared independently by ZHSG, without third-party participation or sponsorship. Perspectives are balanced across ZHSG's multi-disciplinary experience with SNF reimbursement, market trends, and operating challenges. Claim analysis was conducted by our affiliate company Z-CORE Analytics, LLC ("CORE"); utilization from 3,000+ SNFs for services through April 2022 inform our remarks on recalibration and are specific in scope to the CMS rulemaking process.

Summary

We have studied CMS' PDPM parity methodology first introduced in 2021 and updated for the 2023 fiscal year. ZHSG believes the proposed adjustment overstates the impact of provider behavior on SNF Medicare spending during the Public Health Emergency ("PHE").

CMS thoughtfully delayed PDPM recalibration last year, as new data proved the initial spending benchmark too narrow. Given uncertainty about the pandemic's long-term effects on provider operations, CMS should defer, not delay, the PDPM parity adjustment, subject to further study in concert with industry representation.

CMS MAY LACK AUTHORITY TO IMPLEMENT THE PROPOSED METHODOLOGY, as aggregate PDPM payment is impacted by rate construction mechanics that contribute to budget variation. Congressional approval for payment adjustment is explicitly limited to "changes in coding or classification of residents" specified in the Social Security Act.

Regarding comparative integrity, we are concerned that inaccuracies/inconsistencies of data sourced from Medicare Cost Reports distorts payment policy and disadvantages SNFs relative to other providers. Development of a SNF-specific wage index and geographic reclassification policy are necessary and long overdue, having been authorized by Congress in 2000.

Lastly, we find that SNFs are negatively impacted by Medicare policy not specific to the SNF provider designation. We feel these potential reimbursement biases require consideration.

1. **Case-Mix Escalation: "Nature v. Capture"**

In response to previous comments that CMS did not account for the PHE's widespread impact on acuity, CMS revised its methodology so that it "more accurately accounts for these changes while excluding the effect of the COVID-19 PHE on the SNF population." However, research and observation support a shift toward higher acuity since the PHE began, such as a leading care coordination provider finding comorbidity scores increased 11% since 2019. Similar outcomes were evinced by Z-CORE Analytics' UB-04-derived risk adjustment measure, and ISNP discussions about CMS-HCC scores trending above historical averages.

At the height of pandemic disruption, Skilled Nursing was criticized for lack of specialty care capacity. Providers are responding, as evidenced by expansion of SNF-based ventilator care and onsite dialysis programs. Meanwhile, SNF-hospital partnerships have emerged to bridge the narrowing gap between acute & post-acute acuity with SNF-based "intermediate level care." These programs transcend baseline acuity; a small group of new high-acuity SNFs disproportionately drive a poorly targeted parity adjustment that unfairly penalizes traditional providers. Worse, "zero-sum reimbursement" fuels industry backlash, stifling innovation and limiting access to healthcare services that ultimately reduce acute-care spending far exceeding the SNF payment increase.

SNFs face an uncertain future. The PHE may soon end, but Covid's residual effects are just beginning. Millions of Medicare beneficiaries will have recovered from multiple Covid infections and require SNF admission for unrelated conditions; many will suffer variable "Long-Covid" manifestations that must be care planned. Irrespective of the 2023 rule, CMS should address potential reimbursement accommodations as soon as possible.

As a comparable, HIV/AIDS exemplifies how underlying conditions can impact patient care in difficult-to-quantify ways. HIV/AIDS has been studied for decades, yet in the context of PDPM, remains outside the parameters of case-mix adjustment, necessitating this special payment accommodation:

> "(CMS') *results showed that even after controlling for nursing RUG, HIV/AIDS status is associated with a positive and significant increase in nursing utilization. Based on the results of regression analyses, we found that wage-weighted nursing staff time is 18% higher for residents with HIV/AIDS."*

In other words, patients with an HIV/AIDS diagnosis require more care, but no one knows exactly why. HIV/AIDS, as a managed condition, triggers the add-on for all qualifying patients. Residual Covid conditions will likely have a similar effect.

Given the variable nature of symptoms, Long-Covid demands a tempered, data-driven approach to calibrating provider burden before establishing reimbursement policy; to do otherwise is punitive to SNFs and therefore supports deferring the parity adjustment.

2. Claim-Based Analytics

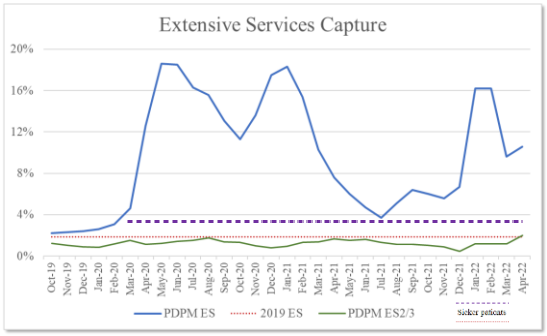
CMS concludes all payment variation between subset and baseline is attributable to provider behavior. Our analysis of services through April 30, 2022, challenges that assumption. Modest rate escalation during the first months of PDPM was likely driven by refined assessment processes, but the value was minimal. Function Scores, unlike ADLs, offset payment between Nursing & PT/OT components, while the most rate-sensitive conditions are clinically and situationally immune to "creep." Extended claims data supports this conclusion:

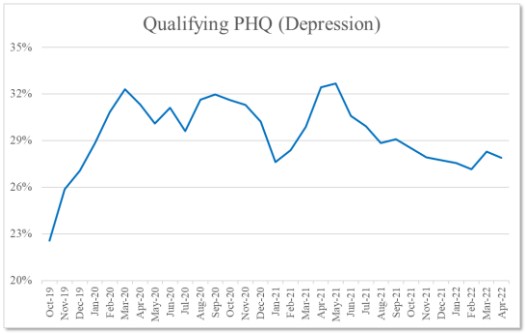
A. Extensive Services. Patients with a Covid diagnosis ("CX") are isolated, grouped into Extensive Services (ES), and excluded from the subset. ES qualifiers cannot be compliantly inflated by provider behavior; they were highly rate-sensitive under RUGs and as such were not underreported pre-PDPM. Therefore, if the subset is accurate and general patient acuity remained constant, the subset should reflect ES% at the RUG-IV baseline; instead, ES days doubled under PDPM, relative to 2019. ES qualifiers also drive NTA scores which further enlarge the parity adjustment. There is no explanation for the ES increase other than higher patient acuity or underrepresentation in the subset. The financial impact is significant; based on our analysis, the 2021 average per diem rate for CX claims added $201/day to the parity total ($808 v. $607, respectively) for every day improperly included within the subset.

   i. Regarding CMS' request for input on expanded Isolation capture criteria, RAI requirements should be adjusted to mirror CDC guidelines.

   ii. Reform policy favors private rooms to improve infection control and promote dignity, but for most SNFs, the configuration is logistically and financially infeasible. CMS could incentivize single room occupancy through an optional program of private placement by default, doubling only when all rooms are occupied. SNFs would be compensated through a "Private Room Differential" (PRD) add-on for every "Single patient bed day" when all rooms are in use. UB-04 Condition Code 38 indicating "Semi-private room is not available" could track qualifying days. Beyond clinical benefits, PRD would right-size bed inventory and ensure access when needed. CMS could arrange Medicaid participation as appropriate and ideally require Medicare Advantage plans to comply as well.

B. Depression capture increased prior to the PHE, but extended claim analysis disproves CMS' assertion that provider behavior fully explained the payment increase. Research concludes lockdowns drove moods above baseline. If provider behavior brought capture up to accurate levels after PDPM implementation, then Depression should have risen again in 2020 Q2 and remained elevated through present day. This did not happen; capture plateaued and, predictably, began retreat as visitation was restored, spiking concurrent to infection waves. We submit that CMS erred in attributing the full financial impact of Depression capture to provider behavior. In fact, ZHSG's audits find PHQ scores are systemically underreported by many SNFs. CMS should reexamine PHQ trends limited in scope to Depression-sensitive RUGs/Nursing CMGs extended through 2022 claims for context.





3. Parity Adjustment Logic

SNF Medicare spending, tempered by Medicare Advantage and reform initiatives, declined for years before rising 4.4% during the PHE; this is less than the 4.6% parity adjustment. CMS' methodology penalizes SNFs by calculating spend using the average rate differential between a subjective PDPM subset and trended RUG-IV baseline. We request clarity on this incongruity and insight as to why DR claims were excluded from the subset's composition.

Waiver ("DR") & Covid diagnosis ("CX") claims presumably drove total the 4.4% increase; both were removed from the parity benchmark. We agree CX must be removed, but our data and perspective differ regarding DR payment. If not for the PHE, CX claims would not exist, but some DR benefits would have occurred. Removing DR only makes sense if the benchmark is total Medicare spend, as opposed to average rate. Our analysis finds DR rates were 1% *lower* than CMS' subset. Applied proportionately, the 4.6% adjustment is reduced to 4.2%. Moreover, because many (if not most) DR "admissions" were dual-eligible SNF LTC residents, Medicaid, Medicare Part B/D savings should be netted from the benchmark. This scenario may entitle SNFs to a *parity adjustment rate increase*.

The parity adjustment logic is muddled; even without concern for collateral acuity and non-identified Covid days misassigned to the subset. We ask CMS to explain how future adjustments will be made if spending continues to trend higher. Providers may believe recalibration is a one-time event; if they are correct regardless of future spend, then there is no rationale for the 2023 adjustment. If parity is addressed annually, how will CMS reconcile new private room standards or data that disproves current assumptions? There are simply too many variables to measure; the financial uncertainty of recalculating a noncomparable benchmark would seem to belie the spirit of the Act.

4. CMS Authority & Variable Per Diem Adjustment ("VPDA")

Per the rule, recalibration is based on CMS' modeling of expected PDPM CMIs "*so that total estimated payments under PDPM would be equal to total actual payments under RUG-IV, assuming no changes in the population, provider behavior, and coding*." However, the systems differ structurally in that PDPM's VPDA "frontloads" reimbursement.

PDPM rates decline significantly after day three; RUG-IV payments were static per assessment window. Irrespective of the pandemic, VPDA is unrelated to capture yet effects parity. If CMS' RUG-PDPM transition model had been accurate with respect to coding, any variation between baseline ALOS and PDPM would unbalance neutrality, potentially triggering recalibration. However, per the Act (highlighted below), ALOS is not an actionable catalyst for adjustment. The parity methodology is therefore in question.

> (e)(4)(F) ADJUSTMENT FOR CASE MIX CREEP – Insofar as the Secretary determines that the adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

VPDA is a rational payment policy, but parity must consider that ALOS has been declining for years; pandemic notwithstanding*, the downward trend will continue. The result is fewer days per admission for frontloaded payment to be amortized, and higher average PDPM rates that may necessitate another adjustment.

* *KFF reports higher ALOS, but this includes CX admissions which trended above average.*

As detailed below, ALOS is sensitive to external factors. If CMS calculates parity based on average per diem rates, then "provider behavior" must extend to other healthcare stakeholders as well. SNFs should not be penalized when hospitals, health systems and convenors implement strategies to reduce SNF days in response to these or other incentives:

A. CMMI initiatives, specifically ACOs and BPCI, exert downward pressure on SNF length of stay to drive shared savings. Our data suggests CMMI-induced compression increased PDPM average rates by more than 3% in active markets prior to the PHE. This distortion will be compounded as CMS realizes its goal of having every FFS beneficiary "CMMI managed" by 2030.

B. Transitional Care Units. PDPM makes no distinction between freestanding and hospital-based SNFs, but we informally define TCUs as hospital-based stepdown units with 30 or fewer beds, ALOS below 20 days, and low Medicaid utilization. PDPM rates increased significantly for TCUs and amplified the parity adjustment. Consider the following:

    i. Short TCU stays drive up the average rate benchmark used for recalibration.

    ii. TCUs often discharge patients to freestanding SNFs, which restarts the VPDA and creates a second shortened admission.

    iii. Higher payment encourages TCU proliferation, thus exacerbating the trend.

While CMS anticipated PDPM to favor hospital-based SNFs under PDPM, the impact of ALOS (a non-case-mix measure) was not factored into the equation. TCUs should be removed from the recalibration formula, and subsequent stays for patients discharged from TCUs to freestanding facilities should be excluded as well.

5. Reimbursement Arbitrage

Medicare & Medicaid funding is often cited as the primary threat to SNF financial stability, but we believe irrational revenue distribution is equally alarming. The SNF revenue model is highly fragmented despite predominance of only two payers. Many services and supplies are unbundled from the room rate, while a growing array of Medicare/Medicaid managed care derivatives remain uncoordinated and non-negotiable. As a result, SNFs have no ability to control prices, and no opportunities to "cost-shift" in the same manner as hospitals.

Medicare Part A may be a distinct program, but the amalgamated reimbursement model is shaped by integrated/codependent revenue components and the alchemy of state & local market dynamics. For example, Medicare FFS utilization is affected by CMMI; Medicare copayment may or may not be covered by Medicaid, ISNP moderates Medicare Part B billing, Medicare Advantage often reimburses based on (heavily) discounted PDPM rates, etc. In this respect, the SNF economic model is unique. Medicare Part A is the center of gravity in the SNF revenue-cycle; payment reductions have a far greater, and geographically uneven, impact on SNFs than any other provider class.

MedPAC maintains that Medicare should not subsidize inadequate reimbursement from other payers. In its approach to payment policy, CMS effectively affirms MedPAC's position; nowhere in the rule does CMS consider the destabilizing and accretive effects of its rulemaking. Medicare does not exist in a vacuum; the near entirety of SNF revenue falls under the auspices of CMS and the watch of MedPAC. CMS should consider SNF-sensitivity when crafting general policy and innovation initiatives outside SNF control.

6. Medicare Advantage

Comments concerning Medicare Advantage are outside the scope of the SNF PPS Rule, but CMS must address the untenable burden MA inflicts on SNF providers. The OIG report on MA denials only begins to tell the story. While hospitals negotiate MA rates exceeding FFS, MA revenue per SNF admission is 30% - 50% below FFS benchmarks, per CORE's MAPAX database of Medicare Advantage claims. This dynamic further pressures Medicare & Medicaid, effectively requiring them to subsidize private insurance companies. Contrary to MedPAC's statements, lower MA payment does not evince Medicare FFS is overly generous; SNF economics do not work that way. MedPAC should recognize Skilled Nursing's high fixed cost model; accepting lower rates is a matter of Contribution Margin, not variable costs.

At some point, CMS must intervene. Until then, we suggest CMS begin studying the escalating threat Medicare Advantage presents to Skilled Nursing.

7. Data Integrity

We are increasingly concerned about the accuracy, consistency, and reliability of SNF data. Specifically, the Medicare 2540 Cost Report ("MCR") is most disconcerting, given its importance as source material for all manner of stakeholders.

MedPAC provides examples supporting the need for consistent standards and enhanced sensitivity. The MCR recognizes only three payers: Medicare, Medicaid & Other. Medicare Advantage represents plurality of beneficiary coverage in many markets, yet MedPAC cites questionable third-party reporting of MA data as justification for reducing Medicare rates.

MedPAC also reports on SNF Medicare Margins, assumedly based on MCR data. Current standards of cost reporting result in diluted routine costs, unreliable and noncomparable ancillary charges, noncontextualized offsets such as coinsurance/bad debt and disregard for CMMI financial distortion, among other concerns clouding these calculations.

The Medicare Cost Report is an essential resource that should be updated as soon as possible.

8. SNF-Specific Wage Index & Geographic Reclassification

Congress authorized CMS to establish a specific wage index and geographic reclassification procedure for SNFs **twenty-two years ago**, but this was never accomplished. The delay is unreasonable and inequitable to SNF providers, even more so through the PHE. Hospitals are eligible for CBSA reclassification and higher Medicare reimbursement, while SNFs in the same markets have no such opportunity. CMS has disadvantaged SNFs by denying them the same reimbursement rights as hospitals. In other words, Medicare's SNF and hospital payment approach lack "parity."

Concurrent to the Medicare Cost Report update, CMS should establish a SNF wage index allowing providers to apply for geographic reclassification. We also ask CMS to explain how inaccurate Medicare Cost Report data potentially impacted PDPM base rates and the proposed parity adjustment.

Zimmet Healthcare appreciates CMS' consideration of these comments.

Respectfully submitted this 9th day of June, 2022.

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