

**Submitter :** Dr. Keith Weikel  
**Organization :** Manor Care, Inc.  
**Category :** Long-term Care

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

**Issue**

Issue

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Case-Mix Adjustment and Other Clinical Issues

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Case-Mix Adjustment and Other Clinical Issues

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## *HCR•ManorCare*

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July 11, 2005

Dr. Mark B. McClellan, Administrator  
Centers for Medicare & Medicaid Services  
**Attention: CMS-1282-P**  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**Re: Comments of Manor Care, Inc on the proposed  
rule on the Medicare Prospective Payment System for  
Skilled Nursing Facilities for FY 2006  
70 Federal Register 20070, May 19, 2005 (CMS-1282-P)**

Dear Dr. McClellan:

Manor Care, Inc. welcomes this opportunity to comment on the proposed rule captioned above that would adopt changes to the Medicare prospective payment system for skilled nursing facilities for FY 2006. Manor Care, Inc., through its operating group HCR Manor Care, is the leading owner and operator of long-term care centers in the United States. The company's nearly 60,000 employees provide high-quality care for patients and residents through a network of more than 500 skilled nursing centers, assisted living facilities, outpatient rehabilitation clinics, and hospice and home health care offices.

**RUGS Refinement**

CMS has proposed the creation of 9 new RUG categories for Rehabilitation and Extensive Services SNF residents to better account for medically complex patients, and an adjustment to the case-mix weights to better account for non-therapy ancillary.

CMS indicates that they are instituting the proposed changes under its authority in section 101(a) of the BBRA to establish case-mix refinements and that the changes CMS is proposing will represent the final adjustments made under this authority. Manor Care is, however, disappointed that CMS failed to take this opportunity under the BBRA

to make substantial changes to significantly improve the SNF PPS. Manor Care is also concerned about the impact of the proposed rule on the financial stability of the long-term care sector, particularly as it relates to nursing homes. By holding aggregate SNF payments in FY 2006 at the same level as in FY 2005, the proposed rule cuts approximately \$510 million from what aggregate SNF payments would have been in FY 2006 without the refinement – i.e. an amount equivalent to the 3 percent market basket update. Research conducted by the Lewin Group and AHCA further suggests that payments for FY 2006 will be an additional \$73.9 million lower in FY 2006 than the proposed rule estimates, and that the adoption of the OMB CBSA designations appears to result in an annualized reduction in payments of \$9 million. While Manor Care recognizes that the design of the proposed rule and the timing of the refinement in part reflects the Administration budget priorities, we urge CMS to undertake appropriate adjustments to the SNF PPS so that it can ensure that payments in FY 2006 are appropriate to deliver quality care and maintain the financial stability of the long term care sector and are at a minimum, no less than the current level of funding.

### **Increase to Better Account for Non-Therapy Ancillary Variability**

The proposed rule includes an adjustment to the case-mix weights for all 53 groups to better account for non-therapy ancillary variability<sup>1</sup>. We applaud CMS for the acknowledgment that the current RUG baseline payments do not adequately account for the cost of non-therapy ancillary services. Congress also acknowledged this fact with the inclusion of add-ons through the BBRA and BIPA provisions<sup>2</sup>.

Through the research by the Urban Institute, CMS determined the need for an increase to aggregate payments for non-therapy ancillaries. As a result of these findings, CMS has in effect determined that the baseline payments to SNFs are under funded. In making this adjustment, CMS under its authority has estimated an amount and proposed a methodology to increase aggregate SNF payments. We however would like to suggest an alternative methodology to accomplish this. **We therefore believe that the additional aggregate payments should be included in the unadjusted nursing case mix component of the rate rather than through an adjustment to the nursing index.**

Another rationale for inclusion of the additional non-therapy ancillary in the base rate is supported by the fact that the cost of non-therapy ancillary services and supplies, which are primarily legend drugs, continue to increase at a rate much greater than the market basket update. By including these costs, as part of the payment base, in the nursing case-mix per diem, it would provide and assure the ongoing funding for these costs including some level of inflation, in order to meet the needs of the heavy-care patients.

In addition, by including the amount in the base rate versus the nursing index, it would eliminate the need for CMS to continually assure that the appropriate adjustment factor is

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<sup>1</sup> 70 FR 29079

<sup>2</sup> BBRA, Section 103 and BIPA, Pub. L. 106-554, Section 313.

included in the nursing index at such time that the index is re-weighted or recalibrated through updated time studies or other factors.

Manor Care believes that the provision of the regulations cited by CMS which allows them to exercise their authority for this adjustment provides wide discretion to the Secretary. The statute neither prescribes nor even implies a methodology, nor does it preclude any specific approach. It does allow for a broad interpretation by the Secretary to implement an "appropriate adjustment to account for case mix," in order to maintain access and quality of care for heavy-care patients.

While the amount included by CMS is a good start, we believe that an increase funding level is necessary to assure access and quality of care to the high acuity high cost Medicare patients. **We therefore ask that CMS reevaluate the rationale used to determine the amount of the adjustment and we believe by doing so, it will increase to a more appropriate level of funding.**

### **Equal Distribution of Payments Throughout the Fiscal Year**

Under the current proposal CMS will reduce per diem payments effective January 1, 2006, with the implementation of the RUG-53 refinement. **In order to assure a more consistent and equitable allocation of the change in the payments rates, Manor Care recommends that CMS adjust the payment rates to result in the equalization of the per diem payments in each fiscal quarter based upon the weighted average for the year.**

We believe that under the authority granted to the Secretary in the Balance Budget Act of 1998, Section 4432(a)(4)(E), CMS must establish average payment rates for the entire fiscal year. The transition to a new payment approach, i.e. RUG-53, does not in itself require the Secretary to establish a differential in rates during the year. Therefore, we believe that it is within the Secretary's authority, even with the net reduction in payment due the proposed RUG refinement, CMS should spread the effect over the entire fiscal year. We provide two options, based on alternative methodologies for the inclusion of the adjustment to better account for non-therapy ancillaries' variation.

#### **Option 1**

If CMS were to include the non-therapy ancillary adjustment in the nursing case-mix rate, as previously recommended in these comments, it is our additional recommendation that the average of the aggregate payments related to the non-therapy ancillary add-ons in the first quarter and the amount applicable to the three subsequent quarters should be included in the nursing case-mix rate.

#### **Option 2**

If CMS were to include the non-therapy ancillary adjustment through the Nursing Index, as currently proposed, it is our recommendation that the applicable nursing and therapy

indexes should be adjusted by an appropriate factor to assure that the aggregate payment rates are averaged throughout the fiscal year. Below is an example that illustrates the calculation of the adjustment factors to be applied.

**Example: Average Payment Approach – Index Adjustment Factors**

<b>Effective Date</b>	<b>Quarterly Rate</b>	<b>Average</b>	<b>Difference</b>	<b>Adjustment Factor</b>
10/1/2005	\$ 336.00	\$ 324.75	\$ (11.25)	0.966518
1/1/2006	\$ 321.00	\$ 324.75	\$ 3.75	1.0116822
4/1/2006	\$ 321.00	\$ 324.75	\$ 3.75	1.0116822
7/1/2006	\$ 321.00	\$ 324.75	\$ 3.75	1.0116822
<b>Average</b>	<b>\$ 324.75</b>	<b>\$ 324.75</b>		

The application to the above adjustments factors could be applied to the proposed payment methodology, using the current RUG-44 for the fiscal quarter and RUGS-53 for the last 3 quarters of the year.

In order to assure future payments are maintained at an appropriate level, the adjustment factor applied in the last 3 quarters must be applied to all subsequent periods.

### **Clinical Issues**

#### **14-Day Look Back**

CMS is seeking comment on potential savings and other impacts of revising the MDS Manual instructions to include only those special care treatments and programs (MDS Section P1a) furnished to the patient since admission or readmission to the SNF. **Manor Care believes that the elimination of the 14-day look back would compromise the ability of the clinical caregivers to provide the most complete and appropriate level of care to Medicare beneficiaries.**

The MDS Section P1a captures special treatments, procedures and programs including chemotherapy, dialysis, IV medication, intake/output, monitoring acute medical conditions, ostomy care, oxygen therapy, radiation, suctioning, tracheostomy care, transfusions, ventilator or respirator care, alcohol drug treatment programs, Alzheimer's/dementia special care units, hospice care, pediatric care, respite care and training in skills required to return the patient to the community.

CMS expresses the view that eliminating the 14-day look-back period will help ensure the accuracy of patient classification and eliminate the number of individuals to classify as Extensive Services category based solely on services that were furnished exclusively during the period before the SNF admission. The CMS rationale for eliminating the look-back period is based on reimbursement concerns only, without regard to the impact

of removing the look-back on patient assessment, transition of care, care planning and quality measurement. Removing the look-back period on MDS Section P1a will negatively impact the quality of care of the beneficiary, care planning, and quality measurement.

MDS Section P1a is the only area on the MDS 2.0 that captures history of recent care requiring extensive services. Eliminating the 14-day look-back period eliminates the care history that must be considered in developing appropriate care plans and in providing quality care.

**We urge CMS to carefully evaluate this issue as it relates to the delivery of patient care and not simply potential savings to the Program and therefore CMS should not eliminate this critical component of the assessment process.**

**Grace Days**

CMS states that it has received recommendations to decrease or eliminate grace day periods for the 5-day PPS assessment. It invites comment on this specific recommendation as well as the option of decreasing or eliminating the grace day periods associated with all PPS MDS assessments. CMS implies that these are policy options that could enhance the accuracy of the payment system and improve quality of care, but does not explain the basis for this assertion. Manor Care does not agree that decreasing or eliminating grace day periods for the 5-day PPS assessment nor decreasing or eliminating the grace day periods associated with all PPS MDS assessments is appropriate. Grace days, properly used, play an important role in providing quality care and receiving adequate reimbursement for that care.

According to the RAI Manual, p2-28, grace days are added to the Assessment Resident Date (ARD) to allow for absence/illness of the RN assessor, reassignment of the assessor, or for an unusually large number of assessments due at the same time frame. Grace days may also be used to more fully capture therapy minutes or treatments but the RAI Manual suggests that they should be used sparingly. The manual warns that routine use of grace days is subject to survey, fiscal intermediary (FI) review and Data Assessment and Verification (DAVE) program review.

Manor Care agrees that grace days should be used carefully and in limited circumstances but, as indicated above, grace days, properly used, play an important role in providing quality care and receiving adequate reimbursement for that care. Appropriate use of grace days is necessary to more fully cover treatment and minutes of therapy.

For example, a patient may refuse therapy for a day due to illness, or temperament. When delays are caused by patient temperament, the patient is transported to the therapy department and staff or staff hired to perform the service cannot do so as scheduled. If the service is not performed, the day cannot be counted for MDS purposes and as a result, the patient does not meet the 5 day/week requirement for a Rehab RUG. In this case, the grace days allow the flexibility of looking back during a time frame that will more

accurately measure the intensity of services provided and delivered to the patient. If the grace days are removed from the 5 day assessment, the Ultra High Intensity RUGs will rarely be met. Reimbursement will be inadequate for the care ultimately being delivered to the patient.

Additionally, grace days can be warranted in relation to late in the day and weekend admissions which are not uncommon practices. In these cases, no evaluation for rehabilitative needs or actual therapy treatment can be considered at the time of admission. If rehabilitation is needed, the most that could be provided to the patient would be 4 days of service which would not produce a rehabilitation RUG. The use of the predictive Section T would produce a rehabilitation RUG but not at the actual intensity of services that would need to be provided.

When properly utilized, grace days are an important aspect of accurate MDS assessment. **We disagree with decreasing or eliminating the grace day period for any PPS MDS assessments.** CMS should continue to thoroughly examine the incidence of "routine use of grace days" to identify specific areas of concern and appropriate modifications.

#### **Proposed Revisions to the SNF PPS Labor Market Areas**

Manor Care, Inc. is in agreement with those comments presented by the American Health Care Association which are reproduced below.

#### ***AHCA Recommendations on the Proposed Revision of SNF PPS Geographic Classifications:***

- *CMS should proceed to develop and apply a SNF-specific area wage index, effective no later than FY 2007, and should immediately request the resources necessary to accomplish this;*
- *CMS should cease depriving SNFs of the ability, enjoyed by the hospitals, to have reclassifications to more appropriate indices, by developing the SNF-specific area wage index required by Congress as the basis of geographic reclassification for SNFs;*
- *Concurrent with the development of a SNF specific wage index, CMS should set in place the procedures for SNF geographic reclassification;*
- *CMS should include methodology in the SNF PPS to establish a "rural" floor for the wage index, such that, as in the case of hospitals, the area wage index applicable to any SNF that is not located in a rural area may not be less than the area wage index applicable to SNFs located in rural areas (or pseudo-rural areas in the case of all urban states);*
- *CMS should not apply the OMB CBSA designations to SNF since it does not have the authority to do so under the SNF PPS enabling legislation, the Balanced Budget Act of 1997 (BBA); and*

- *If CMS takes the position that it has the authority to apply the OMB CBSA area wage designations, CMS should develop and implement the four-year phase-in as outlined by AHCA in order to allow SNFs to make appropriate adjustments in their operations, particularly those SNFs that are most dramatically affected by the proposed changes.*

### Discussion

As part of the notice of proposed rulemaking, CMS invites comments on proposed revisions to the SNF PPS labor market areas. Specifically, CMS is requesting comments on revised definitions for Metropolitan Statistical Areas (MSAs) using the Core-Based Statistical Areas (CBSAs) defined by the Office of Management and Budget (OMB), in the OMB Bulletin No. 03-04, and the immediate implementation of the changes in local labor market area designations.<sup>3</sup>

AHCA is encouraged that CMS is seeking to implement measures that would modify the definition of MSAs to make the payment system more accurately reflect SNF costs associated with local labor market conditions. However, the proposal to adopt the OMB CBSA designations fails to correct inherent deficiencies and distortions in the wage index used to adjust SNF payments to reflect local labor market conditions. The implementation of the OMB CBSA designations without addressing other outstanding issues such as deficiencies in the wage index currently used in the SNF setting, the lack of methodologies in the SNF PPS for geographic reclassification, and the lack of a rural floor, will not improve the accuracy of the payment system. Instead it will inflict unnecessary unintended effects on SNF providers. Given the significant impact of the adoption of the OMB CBSA designations on certain providers, CMS should not proceed with the OMB CBSA designations at this time.

Instead it should first develop and implement a SNF specific wage index that would allow the payment system to more accurately reflect differences in area wage levels and would allow SNFs to request reclassification to alternate, more appropriate local market designations. CMS should also implement provisions that would establish a "rural" floor similar to the inpatient hospital PPS to deal with budget neutrality created anomalies in the SNF PPS. AHCA is eager to work with CMS to bring about needed modifications so that the SNF PPS could better reflect local labor market conditions.

AHCA is concerned that the proposed adoption of the OMB CBSA wage area designation may not only have untoward and distortionary effects, but may also assign MSAs using a tripartite classification scheme that is not permitted by the SNF PPS enabling legislation, the Balanced Budget Act of 1997 (BBA). AHCA believes that CMS' authority is constrained by the organic legislation and that wage indices can only vary as a function of rural or urban location and, further, that CMS lacks the authority to include as a third variant -- a micropolitan location. Thus, CMS should not apply the new classification scheme to SNFs.

However, if CMS takes the position that it has the authority to apply the OMB CBSA area wage designations, CMS should develop and implement an appropriate multi-year phase-in plan that would allow SNFs to make appropriate adjustments in their operations, particularly for those

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<sup>3</sup> See June 6, 2003, Office of Management and Budget (OMB) issuance, Bulletin No. 03-04. In the bulletin, OMB announced revised definitions of Metropolitan Statistical Areas and new definitions of Metropolitan Statistical Areas and Combined Statistical Areas. A copy of the bulletin may be attained at the following Internet address: <http://www.whitehouse.gov/omb/bulletins/b03-04.html>

SNFs that are most dramatically affected by the proposed changes. In addition to a phase-in of the OMB CBSA wage area designations, the phase-in should include the development and implementation of a SNF-specific area wage index, the establishment of a methodology in the SNF PPS for SNFs to request reclassification to alternate more appropriate local market areas, and the establishment of a methodology in the SNF PPS to establish a "rural" floor for the wage index.

In conclusion, AHCA believes that CMS should not proceed with the OMB CBSA wage area designations at this time. CMS should develop the critically important changes referenced above and apply them to SNFs either before, or concurrently with, the OMB CBSA wage area designations -- with an appropriate phase-in that would allow providers to transition to the new index without undue dislocation.

#### **A. CMS Lack Of Authority to Implement OMB CBSA Designations for SNFs**

AHCA is concerned that the proposed adoption of the OMB CBSA wage area designation may not only have untoward and distortionary effects, but may also assign MSAs using a tripartite classification scheme that is not permitted by the SNF PPS enabling legislation, the Balanced Budget Act of 1997 (BBA). AHCA believes that CMS' authority is constrained by the organic legislation and that wage indices can only vary as a function of rural or urban location and, further, that CMS lacks the authority to include as a third variant—a micropolitan location.

In the notice of proposed rulemaking, CMS noted that,

[u]nder the OMB's new CBSA designations, Micropolitan Areas are essentially a third area definition consisting primarily of areas that are currently rural, but also include some or all of areas that are currently designated as urban MSAs. . . . [H]ow these areas are treated [will] have significant impacts on the calculation and application of the wage index. 70 Federal Register 29093

The proposed rule goes on to state that the "statute provides the Secretary with broad authority to use an "appropriate wage index as determined by the Secretary." 70 Federal Register 29091. The proposed rule further notes that the SNF PPS has traditionally used the same methodology for calculating wage indices as CMS has the in-patient prospective system ("IPPS") for hospitals and that IPPS has keyed its classifications to OMB issuances. Thus, according to the preamble, "OMB defined MSAs [Metropolitan Statistical Areas] around a minimum core population of 50,000, and smaller areas were 'Outside MSAs.' On June 6, 2003, the OMB announced the new CBSAs [Core-Based Statistical Area] comprised of MSAs and the new Micropolitan Areas based on Census 2000 data." 70 Federal Register 29091.

While we agree that CMS has broad authority to set wage indices for the SNF PPS, that authority is not unlimited but rather is tethered by the organic legislation. See *Chevron U.S.A. v. Natural Res. Def. Council*, 467 U.S. 837. Under *Chevron*, a court must first determine if Congress has spoken directly to the question at issue. If Congress' intent is clear, the inquiry must end and the court "must give effect to the unambiguously expressed intent of Congress." *Id.* at 843. This is called a *Chevron I* analysis and does not involve deference to the agency. If, however, the court determines that Congress has not directly spoken to the issue and that "the statute is silent or ambiguous with respect to the specific issue," the court must ask whether the agency's interpretation is based on a "permissible construction of the statute." *Id.* This is called a *Chevron II* analysis and in the context of rulemaking the courts will defer to the agency. See *Robert Wood Johnson University Hospital v. Thompson*, 297 F.3d 273, 286 (3rd Cir. 2002) (upholding Secretary's application of wage index provision because "the statute is ambiguous, but ... the Secretary's interpretation is impermissible or unreasonable").

AHCA believes that the organic legislation expressly limits the CMS's authority and that this inquiry ends with a *Chevron I* analysis.

First, the SNF PPS provision consistently recognizes, for payment purposes, only two distinct areas -- rural and urban: "The Secretary may compute and apply such averages [weighted average per diem rate] separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D))."<sup>4</sup>

The Social Security Act (SSA) §1888(e)(4)(D)(iii). The wage index provision for SNF PPS reads as follows:

The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made. SSA § 1888(e)(4)(G)(ii) (emphasis supplied).

While the IPPS provides the Secretary with broad discretion to assign hospitals to urban areas, rural areas, large urban areas, and other regions based on the nine census tracks, this type of express authority is simply not present in the SNF PPS provision which limits the Secretary to the "urban-rural" dichotomy. Indeed, Congress could have easily tied the SNF PPS and IPPS systems directly together by requiring that each shall be governed by the same types of census considerations. However, Congress chose to do otherwise and limited the SNF PPS rulemaking to two geographic areas as opposed to the more expansive authority that the agency has in implementing the IPPS.

Second, the fact the proposed rule mirrors the IPPS system does not save it. Under IPPS, the Secretary has significantly more latitude in setting wage indices that under the SNF PPS and can implement a variety of different types of wage indices that transcend the simple rural-urban dichotomy. Thus, while the use of a third area, the micropolitan area, may be justified under

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<sup>4</sup> Section 1886(d)(2)(D), which applies to IPPS, provides as follows: The Secretary shall compute an average of the standardized amounts determined under subparagraph (C) for the United States and for each region --

- (i) for all subsection (d) hospitals located in an urban area within the United States or that region, respectively, and
- (ii) for all subsection (d) hospitals located in a rural area within the United States or that region, respectively.

For purposes of this subsection, the term "region" means one of the nine census divisions, comprising the fifty States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes; the term "urban area" means an area within a Metropolitan Statistical Area (as defined by the Office of Management and Budget) or within such similar area as the Secretary has recognized under subsection (a) by regulation; the term "large urban area" means, with respect to a fiscal year, such an urban area which the Secretary determines (in the publications described in subsection (e)(5) before the fiscal year) has a population of more than 1,000,000 (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census); and the term "rural area" means any area outside such an area or similar area. A hospital located in a Metropolitan Statistical Area shall be deemed to be located in the region in which the largest number of the hospitals in the same Metropolitan Statistical Area are located, or, at the option of the Secretary, the region in which the majority of the inpatient discharges (with respect to which payments are made under this title) from hospitals in the same Metropolitan Statistical Area are made.

section 1886(d)(2)(D), it is not justified under section 1888(e) which specifically links urban and rural to the definitions of those terms under section 1886(d)(2)(D).

Moreover, creating three categories and then, treating those that fall into the third category (micropolitan) as if they were rurals, has all of the pernicious effects of a tripartite system, but none of its benefits. In short, using a “shadow” third category to artificially inflate the number of hospitals in rural areas is contrary to the legislative intent underlying the SNF PPS provisions.

Though AHCA recognizes that CMS may not have the authority currently to change MSA designations, AHCA also recognizes that CMS’ purpose in proposing the adoption of the OMB CBSA designations is to better reflect local labor market conditions and adjust SNF PPS rates to account for differences in area wage levels. While the purpose is laudable, the proposal to adopt the OMB CBSA designations is at best a half measure that alters but fails to correct inherent deficiencies and distortions in the wage index used to adjust SNF payments to reflect local labor market conditions.

In conclusion, CMS should not proceed with the OMBA CBSA designations at this time. Instead it should first develop and implement a SNF specific wage index that would allow the payment system to more accurately reflect differences in area wage levels and would allow SNFs to request reclassification to alternate, more appropriate local market designations. CMS should also implement provisions that would establish a “rural” floor similar to the inpatient hospital PPS to deal with budget neutrality created anomalies in the SNF PPS. AHCA is willing to work with CMS to bring about needed modifications so that the SNF PPS could better reflect local labor market conditions.

## **B. The Development Of An Appropriate SNF-Specific Area Wage Index**

CMS must proceed with the development and implementation of a SNF specific area wage index for FY 2007. Under section 1888(e)(4)(G)(ii) of the Social Security Act CMS has the authority to adjust for geographic variations in labor costs by using an appropriate wage index. In the absence of an appropriate alternative, CMS has used the hospital wage data to develop a wage index for SNFs, since the inception of the SNF PPS.

The use of hospital wage data and a hospital wage index to establish a wage index for SNFs is inappropriate. As AHCA and others have commented in the past, a SNF specific area wage index is needed to improve the accuracy of SNF payments to providers to better reflect differences in local labor market conditions. The use of the hospital wage index in place of a SNF wage index fails to capture differences in the features, operations and services in those settings, and the differences in skills and activities of staff providing those services. While in some respects SNFs compete with other provider categories for staff, nurse shortages may in fact be much harder for SNFs to overcome than, for example, hospitals, which, given incentives in the system, may be fundamentally more attractive to nurses. Given these and other differences in the labor force and labor markets that hospitals and SNFs draw upon, a geographic area wage index reflecting hospital wage data is in AHCA’s view not appropriate for the SNF setting.

In 1994, the Secretary had been directed to begin, not later than 1 year after the date of the enactment of the Omnibus Budget Reconciliation Act (H.R. 5252), “to collect data on employee compensation and paid hours of employment in skilled nursing facilities for the purpose of constructing a skilled nursing facility wage index adjustment to the routine service cost limits required under Section 1888(a)(4) of the Social Security Act.” Congress provided this mandate 9 years ago.

However, in the SNF PPS proposed rule for FY 2002, CMS reported on its first attempt to gather data to develop a SNF-specific wage index, 66 Federal Register 23985, CMS expressed concern about the reliability of the existing SNF data in view of what the agency considered to be significant variations in the SNF-specific wage data and the large number of SNFs that were unable to provide adequate wage and hourly data. In order to help develop a SNF-specific wage index, AHCA was and remains eager to work with CMS to make any appropriate revisions to necessary forms, revise accompanying instructions and guidelines, and provide information to providers to answer questions during the data collection process.

Subsequently, in the FY 2002 final rule, CMS revealed that it would not dedicate the resources need to develop a SNF-specific wage index. 66 Federal Register 39563. CMS claimed that the necessary auditing would require a significant commitment of resources by CMS and its contractors -- a commitment that CMS refused to make.

There is no question that the development of a SNF-specific wage index would improve the accuracy of SNF payments, and CMS itself has acknowledged this in their FY 2004 SNF PPS final rule, 68 Federal Register 26767. AHCA urges CMS to proceed to develop and apply a SNF-specific area wage index, effective no later than FY 2007. As noted above, AHCA is eager to work with CMS and do what it can to assist CMS to develop an appropriate SNF-specific wage index that would improve the accuracy of payments to SNFs.

**C. The Implementation Of A SNF Geographic Reclassification**

In addition to the development of a SNF-specific wage index, CMS has the authority under Section 315 of the Benefits and Improvement Protection Act of 2000 (BIPA), Pub. L. 106-554, to establish and use a geographic reclassification methodology, similar to the hospital methodology, to allow SNFs to request reclassification to an alternate, more appropriate area that would better reflect local labor market conditions.<sup>5</sup> However, the geographic reclassification system cannot be implemented under current legislation until CMS has collected the data necessary to establish a SNF-specific wage index. Thus, CMS is not only prolonging the use of an inappropriate hospital wage index with its negative impact on the accuracy of the SNF wage adjustment, but it is also depriving SNFs of the ability, enjoyed by the hospitals, to have reclassifications to more appropriate indices. On both accounts, it is thus imperative that CMS develop a SNF-specific wage index.

**D. The Implementation Of A Rural Floor For SNFs**

Section 4410 of the BBA provides that for the purposes of section 1886(d)(3)(E) of the Act, the area wage index applicable to hospitals located in an urban area of a State may not be less than

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<sup>5</sup> The Medicare Geographic Classification Review Board (MGCRB) was established by Congress in 1989. Section 6003(h) of the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) (Pub. L. No. 101-239) created the panel, and set forth criteria for the MGCRB to use in issuing its decisions concerning the geographic reclassification, or redesignation, of hospitals as rural or urban for prospective payment purposes, Soc. Sec. Act §1886(d)(10). Hospitals may be reclassified from a rural area to an urban area, from a rural area to another rural area, or from an urban area to another urban area for the purpose of using the other area's standardized amount for inpatient operating costs, wage index value, or both, 42 CFR §412.230(a). Groups of hospitals may request reclassification of all PPS hospitals located in a county, as long as all of the PPS hospitals in the county or NECMA agree to the request. 42 CFR §412.252(b). Furthermore, 304(b) of BIPA (Pub. L. No 106-554), provided that a statewide entity, consisting of all PPS hospitals within a state, could apply for reclassification for a statewide wage index. 42 CFR § 412.235.

the area wage index applicable to hospitals located in rural areas in the State. In addition, CMS extended this “rural floor” policy for a 3-year trial period by imputing a pseudo rural floor to hospitals in all-urban states. 69 Federal Register 49110.<sup>6</sup> In the hospital setting, this issue appears to arise two ways, first, where there exists a predominant labor market area, and providers located outside of this area must still compete for labor with providers in the predominant labor market area, and second, in settings where a downward adjustment of the wage index in an urban area leads to a wage index that is lower than the surrounding rural areas. Without a “floor” to protect those providers not located in the predominant labor market area from facing continued declines in their geographic wage index, it becomes increasingly difficult for those providers to compete for labor.

In the FY 2006 SNF PPS proposed rule, CMS elects not to apply any rural floor to the SNF PPS wage index. CMS explains that consistent with past SNF policy, it treats this provision, commonly referred to as the “rural floor,” as applicable to acute inpatient hospitals and not SNFs.

CMS does not explain its position which is not reasonable. Similar anomalies exist in the SNF PPS, whereby SNFs located in urban areas could have a wage index that is below the wage index applicable to providers located in rural areas. One such example pertains to Maryland: the Cumberland MD-WV labor index for 2003 was .7847, while the Maryland rural index was .8946. Given the dramatic difference between the wage indexes in this instance, providers in the higher cost more urban area would be at a substantial disadvantage vis-à-vis providers in the lower cost rural area.

It is imperative that CMS apply the rural floor policy to SNFs. There is no statutory impediment to this policy. CMS has chosen to apply the hospital wage index to SNFs and can thus apply any aspect of this index to SNFs unless specifically prohibited by statute. To our knowledge the only specific prohibition is that of the application of the geographic reclassification to SNF until a SNF-specific wage index is produced by CMS.

AHCA recommends that CMS add an appropriate methodology to the SNF PPS to establish a “rural” floor for SNF providers in affected areas and an imputed “rural” floor in all urban states. This methodology should be included in the SNF PPS immediately, irrespective of whether CMS proceeds with or delays the proposed adoption of the OMB CBSA wage area designation.

## **E. OMB CBSA based Wage Index Transition Period Needed**

### ***1. Wage Index Changes Have Significant Impact on Selected SNFs***

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<sup>6</sup> CMS writes “In this final rule, we are adopting a variation of the policy that we discussed in the May 18, 2004 proposed rule. We note first that there are similarities among the three States that are not impacted by the rural floor. Obviously, they are urban States. In addition, each of the three States has one predominant labor market area. That, in turn, forces hospitals that are not located in the predominant labor market area to compete for labor with hospitals that are located in that area. However, because there is no “floor” to protect those hospitals not located in the predominant labor market area from facing continued declines in their wage index, it becomes increasingly difficult for those hospitals to continue to compete for labor. In the BBA, Congress spoke of an “anomaly” in States where hospitals located in urban areas had a wage index that was below the wage index applicable for hospitals located in rural areas. (See H.R. Rep. No. 149, 105th Cong., 1st Sess. At 1305.) We think it is also an anomaly that hospitals in all-urban States with predominant labor market areas do not have any type of protection, or “floor,” from declines in their wage index. Therefore, we are adopting the logic similar to that articulated by Congress in the BBA and are adopting an imputed rural policy for a 3-year period.” 69 Federal Register 49110.

In the SNF PPS proposed rule, CMS argues that it is not appropriate or necessary to propose a transition to the proposed new CBSA-based labor market area for the SNF PPS wage index adjustment, and that the potential benefit of a hold harmless policy for an extremely small number of providers would be outweighed by the resulting decrease in payment rates for all providers. 70 Federal Register 29095. We disagree. Our analysis indicates that numerous providers are negatively affected by the change, particularly those located in rural areas and in certain states.

Analysis by AHCA using data in the addendum to the proposed rule, 2005 OSCAR nursing facility data, and 2002 SNF SAF claims data shows that providers in certain CBSAs, particularly rural CBSAs, and particularly those in rural CBSAs that were previously assigned to urban MSAs, will in many cases be dramatically harmed by the change in the wage index under the proposed OMB CBSA designations compared to the OMB MSA designations.

As noted in the proposed rule, the new CBSA designations recognize 49 new (urban) MSAs and 565 new Micropolitan areas, and revise the composition of many of the existing (urban) MSAs. Under the new CBSA designations 288 new MSAs were established, 41 MSAs were reclassified as Micropolitan areas, and 5 MSAs were reclassified as rural (Carter County, KY; St. James Parish, LA; Kane County, UT; Culpepper County, VA; and King George County, VA). 70 Federal Register 29091.

Overall, about 42.0 percent of counties experience a decline in their wage index, while 35.6 percent experience an increase. Rural counties are more severely impacted, with 51.1 percent experiencing a reduction in their wage index, while 34.9 percent see an increase. Five counties (Kane County, UT; Culpepper County, VA; King George County, VA; Henderson County, TX; and Mohave County, NM) are particularly negatively impacted. The wage index in these five counties drop by more than 20 percent under the proposed OMB CBSA designations compared to the OMB MSA designations.

The impact of the change in MSA designations on SNFs is also dramatic. Research by AHCA has found that 38.1 percent of facilities will experience a reduction in their wage index, while 28.8 percent will see an increase. Rural facilities in particular will be affected negatively, with 56.5 percent of facilities seeing a reduction in their wage index, while only about 32.3 percent would see an increase. Overall, nearly 600 providers will see a reduction in the wage index for their county under the CBSA designations by more than 5 percent, and about 700 providers will see an increase in the wage index for their county of over 5 percent.

The impact will also be felt dramatically in a number of states. Forty-eight percent of facilities in Idaho will experience a reduction in their wage index by more than 10 percent. In addition, 40 percent of facilities in Georgia, 63 percent of facilities in New Hampshire, 23 percent of facilities in Nevada, 16 percent of facilities in Utah, and 11 percent of facilities in South Carolina will experience a reduction in their wage index by more than 5 percent. In Georgia, Idaho, Nevada, and Utah, the bulk of the facilities experiencing these substantial reductions in the wage index are located in rural areas.

In terms of Medicare patient day weighted average per diems (pre- and post- October 1, 2005), analysis by AHCA using 2002 SNF SAF claims data shows that the impact of the change in MSA designation appears relatively small at an aggregated level. Average per diems increased in rural areas by 26 ¢ to \$ 304.83, fell in urban areas by 30 ¢ to \$ 347.87, fell among freestanding facilities by 20 ¢ to \$ 339.37, and fell among hospital-based facilities by 14 ¢ to \$ 338.04. For particular states however, the impact is substantial. The change in MSA designation leads to an estimated reduction in average payments of \$15.08 per day for New Hampshire facilities and

\$8.25 for facilities located in Idaho. Facilities in Arizona and Virginia experience a reduction in estimated average per diems of over \$3 per day, while facilities in New York, Rhode Island, and West Virginia see their estimated per diems reduced by over \$2 per day on average.

Though facilities in a number of states see a substantial increase in average per diems under the OMB CBSA designations (e.g. \$6.78 per day in New Jersey and \$4.16 per day in Nevada), given the dramatic and significant change in the wage index on a number of providers in certain states, particularly those located in rural areas, some type of phase in policy is necessary to mitigate the impact of dramatic changes in the wage index.

## **2. Wage Index Transitioning Proposal**

Given that the adoption of the CBSA designations and application of a SNF-specific wage index would together cause dramatic changes in the wage index for SNFs, CMS should consider making both changes at the same time, and incorporating a multi-year phase-in approach to allow SNFs to transition without incurring significant dislocation and disruption in operations.

AHCA proposes an implementation policy be developed that would phase-in the wage index changes for all facilities. AHCA further proposes that the phase-in be conducted over a four year period to allow facilities to transition to the new system without significant dislocation. Under the AHCA proposal (a variant of option 1 considered by CMS in the proposed rule), the wage index for each provider would consist of a blend of the MSA-based wage index and the CBSA-based wage index. Under the AHCA proposal the blended MSA/CBSA based wage index would be 75%:25% in FY 2006, 50%:50% in FY 2007, 25%:75% in FY 2008, and 0%:100% in FY 2009.

## **IV. The SNF Market Basket**

Manor Care, Inc. is in agreement with those comments presented by the American Health Care Association which are reproduced below.

### ***AHCA Recommendations on the SNF Market Basket:***

- *CMS should base the weights used in calculating the market basket update on the most updated cost data available;*
- *CMS should revise and reweight the SNF market basket with greater frequency – on the same schedule as the hospital market basket;*
- *CMS should complete the Congressionally mandated study on how frequently the hospital market basket should be updated, and update the SNF market basket weights with the same frequency using submitted cost report data; and*
- *CMS should evaluate other options than the ECI for measuring changes in the price of wages and salaries for SNFs. Specifically, CMS should engage in a data collection effort aimed at collecting SNF-specific labor data for the purposes of creating a price proxy for labor costs in SNFs.*

**Discussion**

AHCA has urged CMS to engage in a broad based thorough review of the SNF market basket that would include an analysis of all the weight and price proxy components of the current SNF market basket. To date this process had not occurred, and our concerns remain. We take this opportunity to reiterate two of our primary concerns with the current market basket that have considerable impact on the proposed update for 2006.

First, outdated weights understate cost increases. The weights used in calculating the market basket update were derived from 1997 data. Since then, changes in medical practice, SNF operations, and patient acuity have led to higher than measured increases in costs. Further, the market basket should be revised and reweighted with greater frequency – on the same schedule as the hospital market basket.

Secondly, the price index used to measure changes in the wages of SNF workers, the Employment Cost Index (ECI), is a broad measure the nursing home industry wage changes, but is not specific to SNFs. There is evidence that wages in SNFs are growing faster than in the industry as a whole. CMS should use a SNF-specific wage price index calculated from data gathered from Medicare-participating facilities.

**A. CMS Should Reweight the Market Basket More Frequently**

1997 cost reports are the primary source of the weights, by which changes in the prices of items SNFs purchase are multiplied each year to calculate the market basket update.<sup>7</sup>

However, since 1997, SNFs have undertaken major changes in their operations, such as implementation of the prospective payment system and adopting new technologies. CMS acknowledges these changes in the proposed rule, stating “it became clear that the introduction of the SNF PPS and SNF consolidated billing had caused changes in facility practice patterns and billing. Some of these changes could also have been related to the use of a national database and to changing industry practices...” 70 Federal Register 29075, page 29075. In addition, SNFs have been responding to marketplace changes such as self-funding for professional liability. The assignment of weights within the market basket does not reflect these changes.

It is imperative for the market basket to be reweighted on a regular basis to ensure validity (the market basket accurately reflects the type and level of expenditures in SNF) and accuracy (the impact of price changes of inputs used in calculating the update actually reflect those inputs’ relative importance.)

The Congress recently instructed CMS to study the frequency with which a market basket should be updated in order to be most accurate. The statute requires CMS to reweight the inpatient hospital market basket immediately and to establish a set frequency for revising and reweighting the market basket. The statute instructs CMS to publish an explanation of the reasons the agency chose that frequency. It is very important that CMS undertake this study, because the current frequency with which the market baskets are reweighted appears ad hoc and due to the availability of outside data sources rather than based on considerations of mathematical accuracy.

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<sup>7</sup> Other data sources are the Bureau of the Census’ 1997 Business Expenditures Survey and Bureau of Economic Analysis’ 1997 Annual Input-Output tables. See 66 Federal Register 39582, July 31, 2001.

Even though CMS has been charged with studying the inpatient market basket, the results will likely be applicable to the SNF market basket since many of the inputs and their weights are similar.

We urge CMS to complete the study, mandated by Section 404 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108-173, December 8, 2003, on the appropriate frequency for updating the hospital market basket. We recommend that CMS update the SNF market basket weights with the same frequency as that determined by the study, using submitted cost report data. We believe that this will help to improve the validity of the SNF market basket methodology and the increase the accuracy of the market basket updates.

### **B. CMS Should Use a Different Price Index for SNF Wages**

Our second major concern with the SNF market basket as currently conceived is the use of the Employment Cost Index for Private Nursing Homes, the price index used to calculate wage level changes for nursing home employees. AHCA objects to the fact that the price proxy includes wage price data for entities which are not SNFs and which do not receive payments under the Medicare program. SNF payment levels are being based on wage changes in non-SNF homes.

The ECI measures wage changes across a large, and disparate, group of facilities that the Bureau of Labor Statistics (BLS) lumps together as nursing homes, but which have little resemblance to the operations and patient populations of SNFs. The BLS ECI for Private Nursing Homes contains wage data for:

- Nursing facilities, (Skilled nursing facilities are contained within this category, There are also other facilities that would not include Medicare SNFs included in this category such as facilities which provide skilled care, like long-term care services, but not post-acute care.)
- Intermediate care facilities and mental retardation facilities,
- Community care homes, and
- Other homes, such as personal and domiciliary care homes.

Common sense suggests that the different facilities listed above would employ a distinct mix of workers (meaning they have a different occupational mix). For example, SNFs handle patients discharged from hospitals, needing constant nursing care, rehabilitation, and other skilled nursing services. It is unlikely that the other subcategory facilities would provide that kind of care and thus would not employ the same kind and number of skilled medical workers.

It is unlikely that the ECI is reflective of price changes in SNFs because BLS data show that SNFs employ more skilled medical staff than other types of nursing facilities and that overall, the wages of medical staff are growing faster than the wages of other staff. SNFs employ about twice as many registered nurses, licensed professional nurses, and nurse aides (as a percent of total workers) as other nursing facilities, according to the Occupational Employment Statistics survey (OES).<sup>8</sup>

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<sup>8</sup> Occupational Employment Statistics Survey from 2002-2004. These surveys show that 58% of all staff members in the most skilled nursing facility category are RNs, LPNs, or CNAs. The next highest percent for any category of nursing facility is 30%. The lowest acuity category of nursing homes employs few RNs, LPNs and CNAs (less than 5% of their staff).

**Table 1: 2003 Occupational Mix, by Facility Subcategory, OES**

	Nursing Facilities <sup>9</sup>	Intermediate Care Facilities	Community Care Facilities	Other Care Facilities
RNs	7.73%	2.06%	3.94%	1.29%
LPNs	11.28%	2.21%	5.56%	0.83%
Nurse Aides	37.93%	6.45%	20.08%	1.64%
All Health Workers**	64.45%	34.29%	45.84%	13.29%

The wages of the most prevalent medical staff in SNFs are growing more quickly than for other workers in nursing homes according to BLS OES data. From 2001-2004, the wages of RNs, LPNs and CNAs have outpaced those of other nursing facility workers (from 3-4% wage price growth for nurses versus 2% for all workers). In addition, the wages in skilled facilities for the same types of workers have grown faster than in other settings. For example, wage price growth for RNs was 4.2% in 2003 in skilled nursing facilities, and only 3.6% in other less skilled nursing facilities (see Table 2 below).

**Table 2: Wage Growth from 2002 to 2003, OES data**

	Nursing Facilities	Other Facilities	All Facilities
RNs	4.2%	3.6%	4.0%
LPNs	4.6%	3.6%	4.4%
Nurse Aides	3.4%	1.9%	3.1%
All Workers	3.3%	1.8%	2.6%

As the table below shows, the OES data for nursing facilities, the category that includes the SNFs, show that wage changes in nursing facilities more closely resembled changes in the Hospital ECI than the ECI for Private Nursing Homes last year, indicating that the wage change profile of nursing facilities more closely resembles that of hospitals than it does of all the facilities included in the nursing home ECI.<sup>10</sup>

**Table 3: Change in Wages from 2003 to 2004 across Sites of Care**

Hospital ECI	Nursing Home ECI	Nursing Facility OES
3.5%	2.7%	3.3%

<sup>9</sup> The OES survey does not report number of workers or wage data separately for Medicare-certified SNFs; they are lumped in with the more broad "nursing facility category." It is therefore impossible to tell whether even this category does not represent SNF wage increases.

<sup>10</sup> The percent change in the ECI index value is for March 2003 to March 2004; the OES data are from May 2003 to May 2004. The ECI numbers were accessed June 10, 2005, at: <http://www.bls.gov/news.release/eci.t06.htm>

In sum, it is clear that wage growth in SNFs does not mirror wage growth in other types of nursing facilities for two reasons: SNFs employ more medical workers, whose wages are growing faster than non-medical workers; and the wages of the same types of medical workers are growing faster in SNFs than in other facilities. The ECI for Private Nursing Homes is lower than an ECI specific to SNFs would be, and will continue to be inaccurate as long as the ECI contains wage data from facilities which do not resemble SNFs in occupational mix.

Because the wages weight represents greater than 50% of the market basket, an accurate measure of changes in wage prices is of extreme importance. The current ECI has been an inaccurate measure of wage changes in SNFs for the past 4 years, according to OES data, and will likely remain inaccurate as long as it continues to measure wages across this disparate industry.

We strongly recommend that CMS staff evaluate other options than the ECI for measuring changes in the price of wages and salaries for SNFs. Specifically, we believe CMS should engage in a data collection effort aimed at collecting SNF-specific labor data for the purposes of creating a price proxy for labor costs in SNFs.

### **Consolidated Billing Comments**

Manor Care, Inc. is in agreement with those comments presented by the American Health Care Association which are reproduced below.

#### ***AHCA Recommendations on Consolidated Billing:***

- *CMS should exclude from the SNF PPS consolidated billing the AHCA recommended exclusions; and*
- *CMS should examine current medical practice and modify its policy of permitting certain services to be excluded from the SNF PPS only if provided in a hospital; CMS should permit these same services to be excluded if they are provided suitably and appropriately in sites other than hospitals, chiefly in freestanding clinics.*

### **Discussion**

CMS invites public comment in identifying codes for further exclusions from PPS consolidated billing of services within four categories specified by Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA): chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices. CMS also believes that, given the related report language of the BBRA legislation, the services must be characterized by high cost and low probability in the SNF setting and must represent recent medical advances. AHCA recommendations provided below meet both of these criteria.

In addition, AHCA takes this opportunity to recommend the exclusion of certain other items and services and a change in the site of service policy that permits the unbundling of excluded services only if those services are provided in a hospital.

#### **A. Recommended Drug Exclusions**

In section 103 of the Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. No. 106-113, Congress excluded from the prospective payment system for skilled nursing facilities numerous chemotherapeutic items, as identified by their respective "J Codes," as well as numerous

chemotherapy administration services, also as identified by their respective HCPCS codes. In both instances, Congress explicitly recognized that items “may have been inadvertently excluded from the [exclusion] list[.]” (H.R. Conf. Rep. 479, 106 Cong., 1<sup>st</sup> Sess. 854 (1999)) and therefore, BBRA authorized the Secretary to identify “any additional chemotherapy items” and “any additional chemotherapy administration services” to be excluded from PPS. BBRA § 103(a)(2), amending the Social Security Act by adding new paragraphs at 1888(e)(2)(A)(iii)(I) and (II), codified at 42 U.S.C. § 1395yy(e)(2)(A)(iii)(I) and (II).

The BBRA, however, provided the Secretary no guidance in expanding the list of items or services to be excluded in the future from the prospective payment system. The Conference Report accompanying the legislation, however, noted that the specific chemotherapy items were excluded from PPS because “these drugs are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer.” H. Conf. Rep. 479, 106<sup>th</sup> Cong., 1<sup>st</sup> Sess. 854 (1999). In a subsequent rulemaking, the Secretary, building on the report language, indicated that items or services that were of the same type as described in one of the four categories in section 103, including chemotherapy and chemotherapy services, could qualify for exclusion from SNF PPS if (i) “they also meet the same standards of high cost and [ii] low probability [of being used] in the SNF setting.” 70 Federal Register 29069, 29098 (May 19, 2005), quoting 65 Federal Register 46769, 46791 (July 31, 2000).

We believe that certain chemotherapies that now otherwise qualify for exclusion under the criteria noted above were not part of original BBRA list either because appropriate information was not available at the time, or the items are new and their wide-spread use post-dates BBRA, or Congress inadvertently failed to include them. These drugs are chemotherapy drugs, or cancer chemotherapeutic agents or adjuncts to such agents and are high cost, and have low probability of use in the SNF setting. In short, the drugs listed in Tables 2-6, are the types of items that Congress intended to exclude from SNF-PPS and would have included on the exclusion lists had the information been available at the time. AHCA therefore proposes that CMS excludes the following drugs:

- Certain chemotherapy drugs that meet the high-cost and low probability criteria (Table 2);
- A class of anti-cancer drugs known as antineoplastics. Unlike traditional chemotherapies, these new chemotherapeutic agents are not cytotoxic. Nonetheless they are high-cost and infrequently used in the SNF setting (Table 3);
- Drugs that are traditionally used in combination with chemotherapy, such as antiemetics and supportive care drugs. Those that listed in Tables 4 and 5, are high-cost and low probability drugs; and
- Oral chemotherapeutic agents currently in the Medicare Replacement Drug Demonstration Project. These drugs are part of the demonstration project precisely because they are new, very expensive, and although life-saving, but not covered under part B (until 2006). They have extraordinarily low utilization in a SNF setting (Table 6).

#### ***1. Addition of C Codes to Currently Excluded Drugs – Table 1***

First, we ask CMS to correct a cause of current confusion regarding drugs already excluded. Some chemotherapy drugs have 2 HCPCS assigned - a “J” code and a “C” code. Hospital outpatient departments are mandated to use “C” codes when billing Medicare for some

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chemotherapy drugs under the hospital outpatient prospective payment system. However, the "C" codes are not represented in the excluded chemotherapy drug listing. This has caused confusion. Medicare is rejecting hospital bills for payment and SNFs are being asked to pay for these high cost drugs when in fact, the "J" code for the same drug and dosage is excluded. Below is a listing of the already excluded "J" code chemotherapy drugs with their corresponding "C" codes. CMS should add the following hospital outpatient "C" codes to the excluded chemotherapy list.<sup>11</sup>

**Table 1: "C" HCPCS and Corresponding "J" Codes**

HCPCS "C"	HCPCS "J"	Description
C9417	J9040	Bleomycin sulfate injection
C9418	J9060	Cisplatin 10 MG injection
C9419	J9065	Inj cladribine per 1 MG
C9420	J9070	Cyclophosphamide 100 MG inj
C9421	J9093	Cyclophosphamide lyophilized
C9422	J9100	Cytarabine hcl 100 MG inj
C9423	J9130	Dacarbazine 100 mg inj
C9424	J9150	Daunorubicin
C9425	J9181	Etoposide 10 MG inj
C9426	J9200	Floxuridine injection
C9427	J9208	Ifosfomide injection
C9429	J9211	Idarubicin hcl injection
C9431	J9265	Paclitaxel injection
C9432	J9280	Mitomycin 5 MG inj

**2. CMS Should Exclude the Chemotherapy Drugs In Table 2**

The following chemotherapy codes have not been excluded. CMS should add these chemotherapy drugs, indicated by code below, to the excluded chemotherapy list because they meet the criteria for high cost and low probability.<sup>12</sup>

**Table 2: Non-Excluded "J9" Chemotherapy Agents**

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J9031		Bcg live intravesical vac Bacillus Calmette & Guerin	1 EA	118.41	1 dose diluted in 50ml NS weekly x 6 weeks then every 3 months thereafter	4	\$502
J9035	C9439	Bevacizumab injection	10 MG	57.08	350 mg every 14 days	2	\$3,630
J9098		Cytarabine liposome	10 MG	312.8	50 mg every 14 days	2	\$3,316

<sup>11</sup> CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 360, November 5, 2004, Major Category III, A., Additional Excluded Services Rendered by Certified Providers, Chemotherapy.

<sup>12</sup> These drugs should be added to CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 360, November 5, 2004, Major Category III, A., Additional Excluded Services Rendered by Certified Providers, Chemotherapy.

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J9165		Diethylstilbestrol injection	250 MG	12.14	500 mg daily for 5 days	2	\$121
J9180		Epirubicin Hydrochloride	50MG	No Price available	100-120mg/m <sup>2</sup> 3-4 week cycle	28	No Price available
J9190		Fluorouracil injection	500 MG	1.85	12mg/kg/d on days 1-4 non on day 5 then 6mg/kg on days 6,8 10 12 maintenance max 1g/week	4	\$64
J9202		Goserelin acetate implant	3.6 MG	192.68	3.6 mg daily every 28 days	1	\$204
J9209	C9428	Mesna injection	200 MG	13.43	400 mg every 6 hours for 5 days with ifosfamide	20	\$537
J9213		Interferon alfa-2a inj	3 MIL UNITS	31.17	3 million IU daily for 16-24 weeks	30	\$935
J9214		Interferon alfa-2b	1 MILLION UNITS	12.98	2 million IU 3 times weekly	12	\$312
J9215		Interferon alfa-n3 inj	250000 IU	8.6	For venereal warts N/A	N/A	N/A
J9216		Interferon gamma 1-b inj	3000000 UNITS	292.24	1 million units/m <sup>2</sup> ; 3 times per week	12	\$2,453
J9217		Leuprolide acetate /7.5 MG	7.5 MG	207.14	7.5mg monthly	1	\$220
J9218	C9430	Leuprolide acetate/ Per 1MG	PER 1 MG	10.76	once daily	30	\$323
J9219		Leuprolide acetate implant (Viadur)	65 MG	2,220.98	65mg every 12 months	1	\$196
J9260		Methotrexate sodium inj	50 MG	2.66	30-40mg/m <sup>2</sup> /week	4	\$19

\*Pricing was obtained from CMS Drug files and is based upon payment allowance limits subject to average sales price (ASP) methodology and is based on 4Q04 ASP data.

APC Status Indicator legend: B = not paid under outpatient PPS; G = drug/biological; K = Paid under OPSS separate payment, not bundled; N = bundled.

### 3. CMS Should Exclude The Drugs Provided Used In The Treatment of Cancer – Tables 3,4 And 5

The following is a list of drugs used in the treatment of cancer. These non-excluded drugs are used for the treatment of cancer patients and include antineoplastics, antiemetics and supportive care drugs. The antineoplastic drugs included do not have traditional cytotoxic properties but are drugs that target cancer cells at various stages of reproduction and proliferation. Supportive

medications maintain blood cells, rescue healthy cells from toxic effects of antineoplastic drugs, and counteract the effects of cancer disease processes that spill over to other, nonmalignant organ systems (example: zoledronic acid to treat bone lesions affected by solid tumors). The antiemetics listed are those high-cost drugs used to treat the extreme nausea caused by chemotherapy and not general antiemetics used for other types of nausea. These drugs represent standards of care in oncology practice and are considered part of the chemotherapy regimen by oncologists.

These drugs meet the criteria of high cost and low probability. Most drugs listed below must be used in conjunction with chemotherapy due to the negative medical side effects of the chemotherapy drugs. To exclude chemotherapy from consolidated billing without excluding the drugs and biologicals needed in conjunction with this treatment is to place a financial burden on SNFs, as their costs far exceed the payment received under the PPS. Additionally, hospital outpatient departments are paid extra for these drugs and biologicals, since many are given a separate ambulatory payment classification (APC). In essence, these drugs and biologicals are unbundled for hospitals, but bundled for SNFs. These drugs are administered by injection: intravenously, intramuscularly or subcutaneously.

**Table 3: Non-Excluded Antineoplastic Chemotherapy Drugs**

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J1000		Estradiol cypionate	5MG	5.06	30 mg every 1-2 weeks	3	\$91
J1051		Medroxyprogesterone inj	50 MG	4.94	400 mg weekly	4	\$158
J1380		Estradiol valerate 10 MG inj	10 MG	11.42	30 mg every 1-2 weeks	4	\$137
J1390		Estradiol valerate 20 MG inj	20 MG	14.74	30 mg every 1-2 weeks	4	\$88
J1410		Inj estrogen conjugate 25 MG	25 MG	56.71	25 mg one time, may repeat	2	\$113
J1950		Leuprolide acetate /3.75 MG	3.75 MG	433.73	3.75 mg monthly	1	\$434
J3305		Inj trimetrexate glucuronate	25 MG	137.3	25 mg daily x 5 days	5	\$687
J8510		Oral busulfan	2 MG	1.94	70 mg every 6 hours x 16 doses	16	\$1,087
J8520		Capecitabine, oral, 150 mg	150 MG	3.24	1500 mg twice daily for 14 days	28	\$906

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J9031	C9416	Bcg live intravesical vac Bacillus Calmette & Guerin	1 EA	118.41	1 vial weekly for 6 weeks	4	\$502
J9035		Bevacizumab injection	10 MG	57.08	350 mg every 14 days	2	\$3,630
J9098		Cytarabine liposome	10 MG	312.8	50 mg every 14 days	2	\$3,316
J9165	C9439	Diethylstilbestrol injection	250 MG	12.14	500 mg daily for 5 days	2	\$121
J9202		Goserelin acetate implant	3.6 MG	192.68	3.6 mg daily every 28 days	1	\$204
J9212		Interferon alfacon- 1	1 MCG	3.59	9mcg 3 times/week X24 weeks	12	\$411
J9213		Interferon alfa-2a inj	3 MIL UNITS	31.17	3 million IU daily for 16- 24 weeks	30	\$935
J9214		Interferon alfa-2b	1 MILLIO N UNITS	12.98	2 million IU 3 times weekly	12	\$312
J9216		Interferon gamma 1-b inj	3000000 UNITS	292.24	0.1 mg 3 times weekly every other week	6	\$1,635
J9217		Leuprolide acetate /7.5 MG	7.5 MG	207.14	once monthly	1	\$227
J9218		Leuprolide acetate/ Per 1MG	PER 1 MG	10.76	once daily	30	\$323
J9219		Leuprolide acetate implant (Viadur)	65 MG	2,220.98	65mg every 12 months	1	\$196
J9260		Methotrexate sodium inj	50 MG	2.66	30- 40mg/m2/wee k	4	\$19

\*Typical price calculated as one month/one treatment at 106% average sales price (ASP) as obtained from payment allowance limits according to CMS Drug files (4Q04 ASP data).

**Table 4: Non-Excluded Chemotherapy Related Antiemetic Agents**

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J1260		Dolasetron mesylate	10 MG	6.43	100 mg PO weekly	4	\$191
J1626		Granisetron HCl injection	100 MCG	7.11	70 mcg daily with chemotherapy	5	\$36*
J2405		Ondansetron hcl injection	1 MG	3.73	32 mg daily with chemotherapy	5	\$596
J2469		Palonosetron HCl (Aloxi)	25 MCG	18.09	25mcg 30 minutes before chemotherapy	12	\$230
		Aprepitant (oral)			125 mg once, then 80 mg once daily x 2 per cycle	1 (125mg) and 2 (80mg)	\$116 and \$149

\*Typical price calculated as one month/one treatment at 106% average sales price (ASP) as obtained from payment allowance limits according to CMS Drug files (4Q04 ASP data).

**Table 5: Non-Excluded Chemotherapy Related Supportive Agents**

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J0207		Amifostine	500 MG	428.07	1500mg days 1,8 every 21 days	3	\$3,853
J1190	C9410	Dexrazoxane HCl injection	250 MG	212.45	480 mg weekly	4	\$1,700*
J1436		Etidronate disodium inj	300 MG	67.37	7.5 mg daily for 3 days	3	\$321
J1440		Filgrastim 300 mcg injection	300 MCG	175.14	300 mcg daily	30	\$5,254
J1441		Filgrastim 480 mcg injection	480 MCG	277.15	480 mcg daily	30	\$8,314
J1710		Hydrocortisone sodium ph inj	50 MG	4.69	100 mg twice daily	60	\$158

HCPCS "J"	HCPCS "C"	Descriptor	Dosage	Pricing*	Example regimen	Example # Doses per month	Monthly ASP Pricing
J2320		Nandrolone decanoate 50 MG	50 MG	3.44	50- 100mg/week	4	\$15
J2321		Nandrolone decanoate 100 MG	100 MG	6.66	50- 100mg/week	4	\$28
J2322		Nandrolone decanoate 200 MG	200 MG	13.91	50- 100mg/week	4	\$29
J2355		Oprelvekin injection	5 MG	244.52	3.5 mg daily	30	\$7336*
J2430	C9411	Pamidronate disodium /30 MG	30 MG	57.35	90 mg monthly	1	\$57
J2505		Pegfilgrastim 6mg	6 MG	2,138.60	6 mg once per chemotherapy cycle	3	\$6,416
J2820		Sargramostim injection	50 MCG	20.72	350 mcg daily x 3 per cycle	9	\$1,305
J3487		Zoledronic acid	1 MG	198.72	4 mg every 3-4 weeks	1	\$199
J9209		Mesna injection	200 MG	13.43	400 mg every 6 hours for 5 days with ifosfamide	20	\$537
Q0137		Non esrd epoetin alpha inj	1000 UNITS	9.81	300 units/kg 3 times a week	12	\$2,246

\*Typical price calculated as one month/one treatment at 106% average sales price (ASP) as obtained from payment allowance limits according to CMS Drug files (4Q04 ASP data).

### **3. CMS Should Exclude The Drugs Currently Utilized In the Medicare Replacement Drug Demonstration Project – Table 6**

The following are a list of non-excluded drugs currently in the Medicare Replacement Drug Demonstration Project. These drugs are in this project because they are new, in oral dosage form, very expensive and considered to be life saving chemotherapy drugs, but are non-covered. The demonstration project has made drug coverage available in advance to 25,000 cancer patients. They will be available to all Medicare beneficiaries in January 2006. These drugs have the potential of replacing some of the currently excluded chemotherapy drugs. In fact, many chemotherapy regimens have focused on orally administered cancer drugs because they provide the benefit of allowing patients to be treated in the comfort of their own homes and without incurring costly hospital stays or the dangers of nosocomial infections inherent with intravenously

delivered drugs. Unless these oral agents are also excluded, SNFs will be responsible for payment of these high cost cancer drugs. These drugs meet the test of high cost and low probability.

**Table 6 - Oral Chemotherapy Agents**

HCPCS	Generic	Adult Dose	Unit/Pkg	Price/Pkg*	Price/Month
	Altretamine	100mg 4 times daily x 14 days	50 mg cap 100 caps	\$1,021	\$1,145
S0170	Anastrozole	1 mg daily	1mg tab	\$219	\$219
	Bexarotene	300 mg/m2 once daily	75 mg cap 90 caps	\$1,781	\$3,583
	Erlotinib HCl	Used for titrating doses	25 mg tab 30 tabs	\$730	Depends on Titration up to \$2,380
	Erlotinib HCl	Used for titrating doses	100 mg tab 30 tabs	\$2,084	Depends on Titration up to \$2,380
	Erlotinib HCl	Starting: 150 mg daily	150 mg tab 30 tabs	\$2,380	\$2,380
S0156	Exemestane	25 mg daily	25 mg tab 30 tabs	\$224	\$224
	Gefitinib	250 mg daily	250 mg tab 30 tabs	\$1,806	\$1,806
	Imatinib	Maintenance: 600 mg daily	100 mg tab 30 tabs	\$615	(2x100mg plus 400mg) \$3,669
	Imatinib	Starting: 400 mg daily	400 mg tab 30 tabs	\$2,440	\$2,440
	Letrozole	2.5 mg daily	2.5 mg tab 30 tabs	\$224	\$224
J8700	Temozolomide	150-200 mg/m2 daily for 5 days	20 mg cap 5 caps	\$150	Ex: 225 mg dose \$1,677
J8700	Temozolomide	See above	5 mg cap 5 caps	\$39	See above
J8700	Temozolomide	See above	250 mg cap 5 caps	\$1,836	See above
J8700	Temozolomide	See above	100 mg cap 5 caps	\$744	See above
	Thalidomide	200-1200 mg daily	50 mg cap	Reference unavailable	Estimates: \$10,000 per
	Thalidomide	Depending on indication	100 mg cap	Reference unavailable	Course of treatment
	Thalidomide	See above	200 mg cap	Reference unavailable	See above
	Toremifene	1 tab daily	60 mg tab 30 tabs	\$114	\$114

\*Pricing for these drugs was difficult to obtain as there are no HCPCS found for most of these drugs. Additionally, those drugs with HCPCS codes were assigned "S" codes. "S" codes are

Temporary National Codes that are not covered and are not valid for Medicare and would result in non-payment. Consequently, pricing was obtained from web based Canadian and other online pharmacies, and therefore probably reflect lower costs than might be obtained through normal pricing in the United States.

It should be noted that some of the unit pricing for the drugs listed in the above grids might give the impression of a reasonable charge based on dosing for an average person (around 70 kg, with body surface area 1.5 m2). However, number of units given per treatment in addition to frequency of dosages per day over number of days and weeks would have a significant impact on overall costs. SNFs have been charged for 30 and 40 units of a drug with expenses in the \$10,000+ range.

**B. Radioisotopes And Their Administration**

CMS should exclude the radioisotope drugs provided below in Table 7.<sup>13</sup>

**Table 7: Listing of Excluded Radioisotopes with corresponding hospital outpatient "C" Codes**

HCPCS	Descriptors	Dosage	Pricing	APC Status
C1082, A9522	Supply of radiopharmaceutical diagnostic imaging agent, ibritumomab tiuxetan	per mCi	2,769.63	B
C1083, A9523	Supply of radiopharmaceutical therapeutic imaging agent, yttrium-90 ibritumomab tiuxetan	per mCi	23,976.91	B
C1080, A9533	Supply of radiopharmaceutical diagnostic imaging agent, 1-131 tositumomab	per millicurie	2,565.00	B
C1081, A9534	Supply of radiopharmaceutical therapeutic imaging agent, 1-131 tositumomab	per millicurie	22,230.00	B

It should be noted that a radiopharmaceutical is a radiotherapeutic substance linked to a radioisotope administered to deliver therapeutic radioactivity and combines elements of both chemotherapy and radioisotope categories excluded under BBRA

**C. New Drugs Without Specifically Assigned HCPCS For Exclusion**

CMS should consider new drugs without specifically assigned HCPCS for exclusion, i.e., drugs without specifically assigned HCPCS should be excluded from consolidated billing; i.e., C9399 and J3490 HCPCS, which are codes that represent unclassified drugs, should be excluded from consolidated billing. On May 28, 2004 Transmittal 188, Change Request 3287 reported an amendment to section 1833(t) of the SSA by adding paragraph (15), Payment of New Drugs and Biologicals Until HCPCS Code Assigned. Under this provision, Medicare now covers payment for an outpatient drug or biological that is furnished by a hospital outpatient department for which a product-specific HCPCS code has not been assigned. Hospital outpatient departments are to use HCPCS C9399, Unclassified drug or biological, which is equivalent to J3490. Consequently, SNFs are being held financially responsible for payment of these newly approved drugs that have not been assigned a specific HCPCS code.

<sup>13</sup> CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 360, November 5, 2004, Major Category III, C., Additional Excluded Services Rendered by Certified Providers, Radioisotopes and Their Administration.

Medicare is paying hospitals for these drugs at 95% of AWP. However, SNFs are being charged much higher amounts for these drugs and do not have specific HCPCS to assist in researching the costs or Medicare allowable amounts. Additionally, hospitals have the opportunity to apply for pass-through status on new drugs. Pass-through status provides hospitals with extra payment for the new drugs, as these drugs are considered to have costs that are significant as compared with payments that would otherwise be made. SNFs do not have this opportunity or advantage. SNFs are still required to pay for these drugs with their PPS rates which do not take into account these added high costs. In essence, these drugs are unbundled for hospital outpatient departments, but bundled for SNFs. Also, these drugs meet the exclusionary criteria of beyond the scope of SNF care, high cost and low probability.

#### D. Additional Recommended Exclusions

##### 1. *Magnetic Resonance Imaging (MRI)*

CMS should add the following HCPCS code to its exclusions for magnetic resonance imaging (MRI).<sup>14</sup>

**Table 8:**

HCPCS	Descriptor	Pricing*	Comments
76393	Magnetic Resonance Guidance for needle placement	562.15	This is a magnetic resonance code that was not included in the list of exclusions.

\* Pricing was obtained from 2005 Physician's Fee Schedule

##### 2. *Hyperbaric Oxygen Therapy*

CMS should remove the following HCPCS code for hyperbaric oxygen therapy from the list of non-excluded outpatient surgery and related procedures.<sup>15</sup>

**Table 9:**

HCPCS	Descriptor	Pricing**	Comments
99183	Hyperbaric Oxygen therapy	\$10,000-\$40,000	This procedure meets the criteria of beyond the scope of SNF care, high cost and low probability.

<sup>14</sup> This drug should be added to the list of excluded MRI HCPCS codes in CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 360, November 5, 2004, Major Category III, C., Magnetic Resonance Imaging (MRIs).

<sup>15</sup> CMS should remove the following HCPCS code for hyperbaric oxygen therapy from the list of non-excluded outpatient surgery and related procedures in CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 360, November 5, 2004, Major Category I, F., Outpatient Surgery and Related Procedures.

\* CMS indicates that inclusions, rather than exclusions, are provide regarding outpatient surgery and related procedures because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting.

\*\* Pricing is based on actual invoices from hospitals for hyperbaric oxygen therapy

Hyberbaric Oxygen (HBO) is a medical treatment in which the patient is entirely enclosed in a pressure chamber breathing 100 percent oxygen at greater than one atmosphere pressure. The treatment can cost over \$1,000. HBO does the following:

- increases the concentration of dissolved oxygen in the blood, which enhances perfusion;
- stimulates the formation of a collagen matrix so that new blood vessels may develop;
- replaces inert gas in the bloodstream with oxygen, which is then metabolized by the body; and
- works as a bactericide.

This modality is used primarily to treat decompression illness, carbon monoxide poisoning, and gas gangrene. HBO is also considered acceptable in treating acute vascular compromise and as adjuvant therapy in the management of disorders that are refractory to standard medical and surgical care. The following are the wound care modalities covered:

- Preparation and preservation of compromised skin grafts (not for primary management of wounds -- excludes artificial skin graft). Preservation of compromised skin grafts utilizes HBO therapy for graft or flap salvage in cases where hypoxia or decreased perfusion has compromised viability. HBO therapy enhances flap survival. Should a graft or flap fail, HBO therapy may be used to prepare the already-compromised recipient site for a new graft of flap. HBO therapy is not covered for the initial preparation of a skin graft site and is not considered medically-necessary for the preservation of normal, uncompromised skin grafts or flaps;
- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management. Chronic refractory osteomyelitis is an infection in bone that persists or recurs, following appropriate interventions. Such interventions include the use of antibiotics, aspiration of abscess, immobilization of the affected extremity, and surgery. Medicare Part A can cover the use of HBO for chronic refractory osteomyelitis that has been demonstrated to be unresponsive to conventional medical and surgical management;
- Treatment of osteoradionecrosis and soft tissue radionecrosis. HBO is one part of an overall plan of care, along with debridement or resection of nonviable tissues, in conjunction with antibiotic therapy;
- Treatment of soft tissue radionecrosis as an adjunct to conventional treatment; and
- Diabetic wound of the lower extremities in patients who meet the following three indications:
  - Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;
  - Patient has a wound classified as Wagner grade III or higher; and
  - Patient has failed an adequate course of standard wound care.

The use of HBO therapy is covered as an adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care.

HBO is generally available in university hospital settings since such hospitals have a tertiary patient population referrals base for this specialized treatment. Residents can be treated in the SNF setting for their wound therapy and receive HBO as adjunctive therapy as indicated above. But HBO therapy, as indicated above, is very expensive, and SNF access for these types of patients is at risk of becoming increasingly difficult.

### **B. Site of Service Consolidated Billing Rule**

CMS should modify the site of service consolidated billing rule. Section 4432(b) of the Balanced Budget Act of 1997 (BBA), the consolidated billing requirement, placed on the SNF the Medicare cost and billing responsibility for virtually all of the services that the SNF's residents in a Part A covered stay receive, except for a small number of services that the statute specifically excludes from this provision. As indicated above, Section 103 of the BBRA amended this provision by further excluding a number of high-cost, low probability services within several broad categories that otherwise remained subject to the provision.

However, CMS itself early recognized that some services that patients could receive while in a SNF Part A stay were outside the scope of SNF services. These were, according to CMS, "intensive diagnostic or invasive procedures that are specific to the hospital setting." 63 Federal Register 26298, May 12, 1998. CMS determined that these services, "under commonly accepted standards of medical practice lie exclusively within the purview of hospitals rather than SNFs, and thus were "not subject to consolidated billing." Id. Over time, under this standard, CMS has excluded magnetic resonance imaging (MRI), computerized tomography (CT) scans, ambulatory surgery involving the use of an operating room, cardiac catheterization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures. However, in order to be excluded from PPS, the services must be provided in a hospital. If they are provided in a freestanding clinic, such as a radiation therapy clinic, they are not excluded.

We applauded the exceptions when they were provided because of CMS' recognition that such intensive and invasive procedures are not within the purview of the SNF. In 1998, the advent of PPS, CMS was reflecting then current medical practice in its development of the regulatory PPS exclusions. However, medical practice has changed, and the services in question are no longer exclusively within the purview of hospitals. While they remain outside the purview of SNFs, radiation therapy is now commonly provided in freestanding radiation therapy clinics, and MRIs are available from freestanding entities. Our understanding is that freestanding ambulatory surgery clinics have also been growing.

CMS should examine current medical practice and modify its policy of permitting certain services to be excluded only if provided in a hospital and permit these same exclusions if services are provided suitably and appropriately in sites other than hospitals, chiefly freestanding clinics. This policy change should be considered, at a minimum, for ambulatory surgery, MRIs, and radiation therapy services. Such a modification of this policy will not increase costs to the Medicare program -- and indeed may result in cost savings. Simply put, payment will be made to the freestanding clinic instead of the hospital. There is no reason why a hospital monopoly should be retained when services can effectively, efficiently, and safely be provided in an alternative environment.

Further, there is no legal impediment to this policy change. There is no statute requiring that these CMS-provided exclusions must be provided in a hospital. As indicated above, CMS created this policy based on two factors: (1) that these services that patients could receive while in a SNF Part A stay were outside the scope of SNF services, and (2) that at the time of implementation of the PPS, these were “intensive diagnostic or invasive procedures that [were] specific to the hospital setting.” 63 Federal Register 26298, May 12, 1998. Certain of these intensive diagnostic or invasive procedures are no longer specific to the hospital setting because of changes in medical practice and technology. However they remain outside the scope of SNF services. It is well within CMS’ regulatory purview to update the policy to include providers, in addition to hospitals, who are now commonly providing these intensive diagnostic and invasive procedures.

Furthermore, and most importantly, a change in policy would enormously facilitate access to care in rural areas -- areas that now are being increasingly served by freestanding clinics. The benefit to patients in rural areas is clear. SNFs will not have to transport patients to distant hospitals for provision of excluded services when the services are available from closer freestanding clinics.

### **Qualifying 3-Day Inpatient Hospital Stay Requirement**

Manor Care, Inc. is in agreement with those comments presented by the American Health Care Association which are reproduced below.

#### ***AHCA Recommendations on the 3-Day Stay Requirement for SNF Part A Post Acute Care***

- *CMS should require hospitals should be required to certify that the 3-day stay requirement has been met. In the event of a coverage denial based on the lack of a 3-day stay, the hospital should retain and bear financial responsibility for the stay and not the beneficiary or the SNF;*
- *CMS should include all time spent by a beneficiary in an acute care hospital in the calculation of the 3-day stay requirement;*
- *CMS should exercise the discretion of the Secretary to eliminate the requirement of qualifying 3-day stay requirement; and*
- *CMS should, at a minimum, initiate a demonstration to evaluate the implications of selectively eliminating the three-day inpatient hospital stay requirement.*

### **Discussion**

CMS invites comments on the 3-day hospital stay requirement for SNF coverage. Specifically, for beneficiaries whose formal admission to the hospital as an inpatient is immediately preceded by time spent in hospital observation status, CMS has asked whether CMS should count the time spent in observation status towards meeting the SNF benefit’s qualifying 3-day hospital stay requirement.

AHCA’s position is threefold: First, CMS should require hospitals to certify that the beneficiary has met the requisite 3-day stay. In the event of a coverage denial based on the lack of a 3-day stay, the hospital should retain and bear financial responsibility for the stay and not the

beneficiary or the SNF. Second, all days spent in a hospital prior to the DRG-based stay should count toward the calculation of the 3-day stay. Third, CMS should exercise its authority to eliminate the mandatory requirement of a 3-day hospital stay as a requirement for Part A SNF services. The agency has already done this with regard to the Medicare managed care program wherein Medicare Advantage plans have the discretion to place beneficiaries directly into SNF Part A stays without a prior 3-day stay in a hospital.

**A. Hospitals Should Be Required to Certify That The 3-day Stay Requirement Has Been Met**

CMS should require hospitals, **who are the only entities privy to all the hospital records**, to attest to the existence of a *bona fide* 3-day qualifying stay -- an attestation that the SNF can rely on and that only the hospital can provide. If the attestation later turns out to be incorrect for whatever reason, the beneficiary and the SNF should be held to be without fault, and any recoupment should be made from the hospital. The attestation could be memorialized via hard copy handed to the SNF as part of the hospital discharge/transfer papers or by posting the attestation on an appropriate HIPAA-compliant CMS web site, established solely for this purpose.

In 2003, the Office of the Inspector General (OIG) of the Department of Health and Human Services issued a series of reports to all fiscal intermediaries (FIs) calling for recoupment of claims that the OIG believed may have been paid incorrectly due to the potential lack of a 3-day stay.<sup>16</sup> The OIG's review encompassed calendar years 1997 through 2001 and to SNF stays nationwide. AHCA aggressively opposed recoupment on many grounds. On November 26, 2003, CMS, with concurrence from the OIG, informed the FIs that they should **not** seek to recover the payments identified by OIG in these studies. In addition, CMS stated that if the FIs had already recovered funds as a result of implementing the OIG findings, they were to immediately reverse these transactions, and return the payments to the providers.

The OIG reports themselves and AHCA analysis have provided ample evidence of the difficulties involved in the correct determination, administration, and review of the 3-day stay rule. CMS in its directive to the FIs declared that its central office staff were working with OIG to analyze its existing policies, and to make recommendations for future action. We are not aware of any recommendations that CMS has made and continue to believe that the hospital must incur the obligation, and administrative and financial responsibility, for correctly determining the 3-day stay. The difficulties that were raised by the OIG and AHCA which led to the rescission of the recoupment directives must be considered by CMS.

**1. It Is Virtually Impossible for CMS to Verify a Qualifying 3-Day Stay**

The OIG itself acknowledged that it is "virtually impossible" for CMS to verify that a 3-day stay has occurred. In the reports, the OIG said that it attributed the "significant" amount of improper Medicare SNF payments to the lack of automated procedures within the CMS common working

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<sup>16</sup> The OIG Reports included the following: : A-05-02-00087 (UGS) March 2003; A-05-02-00086 (Administar Federal) March 2003; A-05-02-00088 (Palmetto GBA) March 2003; A-05-03-00036 (First Coast Services Options, Inc.) March 2003; A-05-03-00026 (Care First of Maryland, Inc) March 2003; A-05-03-00083 (Mutual of Omaha) March 2003; A-05-03-00015 (Riverbend GBA) April 2003; A-05-03-00022 (Empire HealthChoice) Inc. May 2003; A-05-03-00051 (Cahaba Government Benefit Administrators) July 2003; A-05-03-00035 (Veritus Medicare Services) July 2003; A-05-03-00050 (TriSpan Health Services) September 2003; A-05-03-00086 Arkansas Blue Cross and Blue Shield) October 2003; and A-05-03-00087 (Blue Cross and Blue Shield of Georgia, Inc.) October 2003.

file (CWF) and the FI claims processing systems. It indicated that for many reasons SNF claims cannot be matched against a history file of hospital inpatient claims to verify that a qualifying hospital stay preceded the SNF admission. The OIG concluded that neither the CWF nor the FIs have an automated means of assuring that the SNF claims are in compliance with the 3 consecutive day inpatient hospital stay regulations and eligible for Medicare reimbursement.

The OIG failed to state that the SNF also lacked an automated means of assuring that its claims are in compliance with the 3 consecutive day inpatient hospital stay regulations. Further, the OIG stated that instead of an automated match of inpatient and SNF claims data, SNFs were on an honor system. It failed to state that the hospitals were also on the honor system, but that the choice of the term "honor system" carried with it the clear implication that when something goes wrong in this process, it is a breach of the honor system. AHCA pointed out that this approach, which utterly neglects the inherent difficulties and deficiencies in the 3-day determination process, was misleading, gratuitous, and harmful to providers and their hardworking SNF staff.

## ***2. The Applicable Rules Complicate the Determination of a Qualifying 3-Day Hospital Stay***

At the time of the OIG reports, AHCA could not know, and obviously neither could the OIG, the FIs, nor CMS have known, how many of the alleged ineligible stays would actually turn out to be ineligible. We believed that many of them had the potential of being eligible due to factors such as the interplay of the 3-day rule and the so-called 30-day transfer rule and other complicating and extenuating circumstances. We stated our belief that the OIG should have provided such information in its reports as necessary regulatory background to understanding the nature of the FI databases.

Pursuant to Section 1812(a) of the Social Security Act, a Medicare beneficiary is eligible to receive "post-hospital extended care services" or SNF benefits under Part A for up to 100 days during any spell of illness. Section 1861(i) provides that the term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which the beneficiary was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer.<sup>17</sup> The beneficiary must have been admitted to the SNF within 30 days after discharge from the hospital, or within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital.<sup>18</sup> This rule is referred to as the 30-day transfer rule.

<sup>17</sup> As discussed further below, the 3-day rule is a blunt and crude instrument for controlling the utilization of Medicare Part A skilled nursing services. It has no clinical basis and should be reexamined as a requirement for a SNF Part A stay. The Medicare Catastrophic Coverage Act of 1988 (repealed in 1989) eliminated the 3-day stay in addition to providing other important and beneficial modifications to the Medicare SNF benefit -- unfortunately for a very brief period of time.

<sup>18</sup> Skilled Nursing Facility Manual (CMS-Pub. 12), § 212.3 (A) provides as follows: "In determining the 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days. For example, a patient discharged from a hospital on August 1 and admitted to an SNF on August 31 was admitted within 30 days. The 30-day period begins to run on the day following actual discharge from the hospital and continues until the individual is admitted to a participating SNF, and requires and receives a covered level of care. Thus, an individual who is admitted to an SNF within 30 days after discharge from a hospital, but does not require a covered level of care until more than 30 days after such discharge, does not meet the 30-day requirement...If an individual whose SNF stay was covered upon admission is thereafter determined not to require a covered level of care for a period of more than 30 days, payment could not be resumed for any extended care services he may subsequently require even though he has remained in the facility. Such services could not be deemed to be "posthospital" extended care services...."

Another aspect of the 30-day transfer rule is provided in the SNF Manual at 212.3(c). The manual provides that if an individual who is receiving covered posthospital extended care leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days, the 30-day transfer requirement is considered to be met. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to an SNF. The fact that the period of extended care services could be resumed without hospitalization also means that the period could be resumed with less than a 3-day hospital stay.

The interplay of the 3-day stay and the 30-day transfer rule illustrates how a hospital stay that is less than 3 days may actually be a second hospital stay in a benefit period. This could happen in at least the following two ways:

- A beneficiary has a 3-day hospital stay and is admitted to a SNF from the hospital. The beneficiary remains in the SNF for more than 30 days and is discharged to the hospital. She/he has a hospital stay of less than 3 days and is discharged back to the SNF. Within the OIG database, however, the SNF readmission would be erroneously associated with the second hospital stay which was within the 30 days, but less than a 3-day stay.
- A beneficiary has a 3-day hospital stay and is admitted to a SNF within 30 days. The beneficiary is discharged to home care from the SNF with benefits remaining. Within 30 days of the discharge from the SNF, the beneficiary is readmitted to the hospital and stays less than 3 days and is once again admitted to the SNF. The beneficiary would still be eligible to use the remaining SNF benefit on the basis of his/her return to the SNF within 30 days of the previous SNF stay. Again, within the OIG database, the SNF readmission would be erroneously associated with the second hospital stay which was within the 30 days, but less than a 3-day stay.

In addition, CMS permits a lapsed period of more than 30 days for SNF admissions where the patient's condition makes it medically inappropriate to begin an active course of treatment in a SNF within 30 days after hospital discharge. A variety of circumstances and examples pertaining to the exception are provided in the CMS Skilled Nursing Facility Manual (CMS-Pub. 12) Section 212.3. See Attachment 1. It is clear that the overall complexity of the application, and exceptions to the application, of the 3-day and 30-day rules can severely undermine correct and clear determination of the inpatient 3-day stay.

Mutual of Omaha, in its response to the OIG report, also provided additional reasons, alluded to above, as to why there might be inaccuracies in the OIG data. Mutual pointed out that since the auditors did not review medical records, some conclusions and extrapolation might be inaccurate. The FI was of the opinion that further review of the claim history and medical records would be needed to determine if any other factors were contributory, such as the following:

- The qualifying hospital stay occurred at a VA or other non-Medicare facility, for which CWF would have no record.
- The beneficiary may have been in a Medicare+Choice HMO and disenrolled from the HMO before admission to the SNF, in which case CWF would not have a record of the hospital stay.
- A physical disaster situation, such as a hurricane, flood, etc., occurred whereby CMS approved the payment of the SNF stay without a qualifying hospital stay.

- The hospital stay was paid “outside of CWF” in accordance with a special process allowed by CMS to allow payment to be made when there is a system problem.

Obviously it was not known how many of the alleged ineligible claims will prove to be eligible based on the factors discussed above. However, the OIG should have acknowledged and provided information on these factors and complexities. Its silence on these matters may have contributed to a totally misleading characterization of SNF behavior.

### **3. The Hospitals Alone Have Control of The Qualifying Information**

As the OIG pointed out, there is no automated means for the CWF nor for any FI to assure that the SNF claims are in compliance with the 3-day rule. Even more importantly, there is no automated means for the SNF itself to have such assurance. The SNF must depend on the quality of the (generally faxed) transfer papers arriving with the beneficiary from the hospital, the competence and honesty of the hospital discharge planners (who are also on a so-called honor system), and the mutual comprehension of the hospital and SNF staff of the impact of the 3-day rule in the individual circumstances of each and every discharge from a hospital to a SNF. Unfortunately, given the current system, the opportunity for mistakes are legion. While this was not acknowledged by the OIG in its reports, we believe that this fact greatly influenced the OIG’s agreement to withdraw the recoupment directives.

We have heard and continue to hear from providers about the difficulty of dealing with some hospitals and getting from discharge planners indisputably correct information on many issues, including the existence of a *bona fide* 3-day stay.

The first and foremost problem with SNF reliance on the hospital for admission information is the issue of what constitutes a 3-day inpatient stay for the purpose of SNF Part coverage. A transfer form will have the day of hospital admission and the day of hospital discharge. Hospital staff themselves are not particularly focused on the problem of what constitutes an admission day for the purpose of SNF claims because of a lack of an appropriate 3-day stay. Likewise, hospital staff are not always aware that, currently, emergency room and observation stays cannot constitute part of the 3-day span. This is compounded by the fact that Medicare law and other CMS rules pertaining to the hospital itself work to confound the issue by requiring that the costs of services provided to patients during the 3 days immediately preceding the date of the patient DRG admission be considered operating costs of inpatient hospital services and bundled to the DRG stay and payment.<sup>19</sup> As we argue below, a more logical policy would be for CMS to include all days immediately preceding the DRG component in the calculation of the 3-day stay requirement to enable beneficiaries to receive their SNF Part A benefits.

Secondly, dates of admission and discharge on the transfer forms can be wrong, and verification of the dates with hospital staff can be unnecessarily challenging -- and perhaps part of a larger problem regarding the exchange of information between hospital and SNF staff. The primary means of hospitals communicating with nursing facilities regarding a pending placement is via a fax machine. Often, the records sent are abbreviated or unreadable because of poor fax access or print quality. (No one wants to wait for a 50-page fax to go through, so the hospital staff may only send the 15 pages that they think are important.) Indeed, hospital discharge planners generally have little awareness of the need for nursing facilities to collect data for a variety of reasons such as for the Assessment Reference Date (ARD) or “look-back” periods that include hospital stay days.

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<sup>19</sup> See Section 1886(a)(4) of the Social Security Act and Medicare Claims Processing Manual, Pub. 100.4, Chapter 3 Inpatient Hospital Billing, Section 40.3 Outpatient Services Treated As Inpatient Services.

Lastly, because of financial pressures, few facilities can afford to send an assessment nurse to the hospital to more adequately determine the condition of each potential resident before admission. Therefore, the facility is left to rely solely upon information from the admitting physician and whatever information the hospital chooses to send. Complicating this situation is the increasing frequency of "last-minute" discharges from hospitals, often on Friday to reduce the weekend staffing pressures on the hospital. If a new resident arrives at a nursing facility late Friday afternoon, nursing facility staff may not be able to reach the hospital's nursing supervisor, discharge planner, or other knowledgeable professional until the following Monday.

In conclusion, many problems, articulated above, can contribute to the inaccurate calculation of the 3-day stay. CMS obviously has to address and resolve all of these problems in an effort to make the 3-day stay a viable and operationally-feasible requirement for a post acute SNF stay. The first step is to CMS should require hospitals, **who are the only entities privy to all the hospital records**, to attest to the existence of a *bona fide* 3-day qualifying stay -- an attestation that the SNF can rely on and that only the hospital can provide. If it transpires, later, that the attestation was incorrect for whatever reason, the beneficiary and the SNF should be held to be without fault, and any recoupment should be made from the hospital.

#### **B. All Time Spent By A Beneficiary In An Acute Care Hospital Must Be Counted for Purposes of Meeting the 3-day Stay Requirement**

As indicated above, CMS invites comments on whether CMS should consider the possibility of counting the time spent in observation status toward meeting the SNF benefit's qualifying 3-day hospital stay requirement. AHCA's position is that **all** days spent in a hospital prior to the DRG based stay should count toward the calculation of the 3-day stay, and AHCA has long argued this to CMS. In addition, AHCA is part of a coalition of 18 associations and groups who have collectively argued to CMS that beneficiaries' access to care and services continues to be jeopardized by the interpretation of federal law that denies Medicare reimbursement for SNF stays when the beneficiaries have been hospitalized for three or more days.<sup>20</sup> The coalition wrote to CMS in 2003 and 2004 that no change in law was needed and that we were seeking modifications only in CMS' Medicare manuals to make them recognize and conform to contemporary medical practice. We wrote that "In light of declining hospital lengths of stay since the Medicare program was first enacted – the average length of stay for older people who were hospitalized declined from 12.6 days in 1970 to 5.8 days in 2001 – these modifications are necessary to assure that Medicare beneficiaries receive the SNF-covered care to which they are entitled."<sup>21</sup> This continues to be AHCA's position.

##### ***1. Declining Hospital Length of Stay Threatens Beneficiary Coverage***

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<sup>20</sup> Alliance for Retired Americans, American Association of Homes and Services for the Aging, American College of Health Care Administrators, American Federation of State, County, and Municipal Employees, American Health Care Association, American Medical Directors Association, Catholic Health Association of the United States, Families USA, Morris J. Kaplan, Esq., NHA, Gwynedd Square Nursing Center (Lansdale, PA), Medicare Rights Center, National Academy of Elder Law Attorneys, National Association of Directors of Nursing Administration in Long Term Care, National Association for the Support of Long-Term Care, National Association of Professional Geriatric Care Managers, National Association of Social Workers, National Association of State Long-Term Care Ombudsmen, National Citizens Coalition for Nursing Home Reform, and the National Senior Citizens Law Center.

<sup>21</sup> Letters to Laurence D. Wilson from Toby S. Edelman, Center for Medicare Advocacy, Inc, July 3, 2003 and July 15, 2004 on behalf of the above referenced coalition of 18 association and groups.

According to the Medicare Advisory Commission (MedPAC), the average length of hospital stays fell more than 30 percent during the 1990s, with annual declines exceeding 5 percent from 1993 to 1996. The decline has continued through 2003 though slowing to 1.3 percent in 2003.<sup>22</sup> Congress itself had developed concern over declining lengths of stay when, in the Balanced Budget Act (BBA) of 1997, it expanded Medicare's transfer policy to include discharges to PPS-exempt hospitals and other post-acute settings. According to MedPAC, at the time the Congress was considering this policy, data showed Medicare inpatient length of stay had dropped 22 percent between 1990 and 1995.<sup>23</sup> According to FY 2004 MedPar data, out of the 523 valid DRGs, 61 DRGs (11.7 percent) had geometric mean lengths of stay of less than 2 days, 213 DRGs (40.7 percent) had geometric mean lengths of stay of less than 3 days, and 322 DRGs (61.6 percent) had geometric mean lengths of stay of less than 4 days.<sup>24</sup>

Given the dramatic shift in hospital length of stays, it is imperative that CMS revisit its policy regarding calculation of the 3-day stay. CMS itself acknowledges a key factor -- that at the time Medicare was enacted the concept of observation status itself was not yet even envisioned. CMS admits that it is aware that over time, practice and treatment of observation time may have changed and that thus the effect of not counting this observation time under the existing policy ultimately might be to restrict SNF coverage to a narrower segment of the beneficiary population than the Congress originally intended.

Despite CMS' insight into the negative impact of not counting observation days, the agency suggests that it is noteworthy that Congress has not chosen to amend section 1861(i) of the Act specifically to reflect use of observation time as triggering the SNF benefit. However, Congress need not legislate changes in policies that are purely creatures of regulation. CMS itself invented the exclusion of observation days and all time spent in the hospital from calculation of the 3-day stay. Congress does not need to act in order CMS to change a policy that is so harmful to the legitimate application of beneficiary Medicare benefits.

***2. Medicare Law Permits The Secretary to Include All Time Spent in The hospital to Be Counted Towards the 3-Day State***

Indeed, there is no statutory impediment to the change. Under the Social Security Act, post-hospital extended care services are covered by Medicare hospital insurance if the patient is "transferred from a hospital in which [s]he was an inpatient for not less than 3 consecutive days before [her] discharge from the hospital in connection with such transfer." 42 U.S.C. §1395x(i). The Secretary has full authority to interpret the term "inpatient" in a manner that would define the 3-day stay as including all time spent in the hospital but has chosen not to do so.<sup>25</sup> CMS itself acknowledges that the policy of not counting all the time spent in a hospital towards the 3-day stay is no more than a "longstanding policy interpretation" of the governing law and does not claim that it is barred from re-interpreting the statute to expand the concept of the 3-day stay.

CMS, however, is obviously bothered by the fact that the Section 1886 requirement discussed above (i.e., that the costs of services provided to patients during the 3 days immediately preceding

<sup>22</sup> Report To The Congress, Medicare Payment Policy, MedPAC, March 2005, page 46.

<sup>23</sup> Report To The Congress, Medicare Payment Policy, MedPAC, March 2000, page 81.

<sup>24</sup> Notice of Proposed Rulemaking, Hospital Inpatient Prospective Payment System, 70 Federal Register 23306, May 4, 2005, Table 5, at page 23415.

<sup>25</sup> See 42 CFR 409.30 and Medicare Benefit Policy Manual, Chapter 8 – Coverage of Extended Care (SNF) Services Under Hospital Insurance, Section 20.1.

the date of the patient DRG admission are to be considered operating costs of inpatient hospital services and are bundled to the DRG stay and payment) could be used to support counting these same days as part of the 3-day post-acute requirement.

CMS argues that the deeming requirement in section 1886(a) and the 3-day requirement for SNF coverage in section 1861(i) serve different purposes. The deeming requirement in section 1886(a) was intended to prevent hospitals from “unbundling” services from the inpatient stay and inappropriately seeking separate payment while the purpose of the 3-day inpatient stay requirement for SNF coverage is to target SNF coverage to individuals requiring a short-term, fairly intensive stay in a SNF as a continuation of an acute hospital stay. CMS argues that Congress chose to target SNF coverage to individuals who had been inpatients for at least 3 consecutive days; the Congress could have chosen a shorter time, or it could have specified that certain time before admission must be counted for purposes of the 3-day requirement, but it did not. CMS thus concludes that the requirement in section 1886(a) of the Act to treat certain preadmission costs as inpatient costs) is consistent with not counting time spent in the hospital prior to an individual’s inpatient admission as inpatient time, for purposes of the 3-day requirement for SNF coverage under section 1861(i) of the Act.

In so arguing, CMS forgets its own acknowledgments that at the time Medicare was enacted the concept of observation status itself was not yet even envisioned, that over time, practice and treatment of observation time may have changed and that thus the effect of not counting this observation time under the existing policy ultimately might be to restrict SNF coverage to a narrower segment of the beneficiary population than the Congress originally intended. Lastly, if the purpose of the 3-day inpatient stay requirement for SNF coverage, as CMS argues, is to target SNF coverage to individuals requiring a short-term, fairly intensive stay in a SNF as a continuation of an acute hospital stay, including all time spent in the hospital towards the 3-day stay in no way abrogates that purpose.

### ***3. Both Emergency Room Time and Observation Days Should Be Included In the 3-Day Stay Requirement***

CMS goes to great lengths to distinguish the nature of observation time from time spent in the hospital’s emergency room indicating that it is not willing to consider time spent in an emergency room toward the calculation of the 3-day stay. CMS argues that although both observation services and emergency room services are directed at patients who are expected to spend only a short period of time in that service area, they are in many other ways dissimilar and details what it considers to be the dissimilarities.

CMS’ exercise is irrelevant to the issue, however. The issue is not what constitutes emergency room outpatient services as opposed to observation days. AHCA is not trying to change or expand emergency room or observation services as provided and paid for by Medicare. The issue is rather that the time spent receiving emergency room services or observation services should count toward the 3-day stay when this time is followed by admission to a DRG stay. The patient is the same patient and the services received – diagnostic etc. – as an emergency room outpatient or as an observation stay patient have confirmed the acuity of the patient and the need for acute care which has, in effect, already begun. As indicated by the United States District Court in *Elizabeth Jenkel v. Shalala*, all such days should be counted, given the likelihood that any patient who is “formally” admitted as an inpatient after an emergency or observation stay has experienced a continuous course of care.

The court held that the 3-day requirement was met by a combination of one night in the emergency room and two days in the hospital after formal admission.<sup>26</sup> The court said that “the sequence of events established a continuous course of care that began when the beneficiary was treated in the emergency room and continued until her discharge and transfer to the SNF. Neither the beneficiary’s condition nor the course of treatment varied from the time of her arrival at the emergency room to the time of her formal admission. Accordingly, the ALJ erred in reasoning that the beneficiary’s hospital stay did not begin until she was formally admitted. The beneficiary’s formal admission as an inpatient was merely a ratification of her de facto admission when she arrived at the emergency room. Therefore, the beneficiary satisfied the three-day prior hospitalization requirement, and the SNF services she subsequently received were covered.” See CCH Paragraph 42,121, Attachment 2.

In conclusion, there is no reason to exclude emergency room services from inclusion in the 3-day stay calculation.

### **C. The Requirement of a 3-Day Inpatient Hospital Stay Should Be Eliminated or Modified**

AHCA strongly recommends that CMS exercise the Secretary’s discretion under the Social Security Act and eliminate the requirement for a three-day hospital inpatient stay.<sup>27</sup> As indicated above, the 3-day rule is a blunt and crude instrument for controlling the utilization of Medicare Part A skilled nursing services. It has no clinical basis and should be reexamined as a requirement for a SNF Part A stay. While it is obvious that the treatment of certain conditions/diagnoses require a hospital stay, it is also obvious that there is no rational basis for a universal requirement of a 3-day regardless of diagnosis. Indeed, the Medicare Catastrophic Coverage Act of 1988 repealed the requirement and relied on physician determination of the appropriate site of care.<sup>28</sup>

The requirement is also unworkable and deficient as a process for gate keeping as evidenced by the OIG reports directing recoupmnt due to SNF claims allegedly lacking the 3-day stay discussed above.

The current CMS policy may reflect an incomplete understanding of the benefits for Medicare patients associated with eliminating this outmoded and essentially arbitrary precondition for covering a SNF stay under Part A of Medicare. The reluctance may also stem from concerns about the potential cost of eliminating the three-day inpatient hospital stay requirement.

#### **1. Cost Impact of Eliminating the 3-Day Stay**

AHCA believes that eliminating the three-day stay will increase neither overall health care spending nor Medicare costs.

<sup>26</sup> *Report and Recommendation of Smith*, U.S. Magistrate U.S. District Court, District of Connecticut, No. 2:92-290 (AHN), Dec. 21, 1993, Magistrate’s report and recommendation adopted by the court Jan. 26, 1994.

<sup>27</sup> Under Section 1812(f) the Secretary may authorize coverage of SNF care without a prior hospital stay if two conditions are met; first, the coverage of these services must not result in any increase in Medicare program payments, and second, the coverage must not alter the acute care nature of the benefit. CMS has determined that these conditions are met in the case of SNF services furnished by a Medicare Advantage plan that covers SNF services.

<sup>28</sup> The Medicare Catastrophic Coverage Act of 1988 eliminated the 3-day stay in addition to providing other important and beneficial modifications to the Medicare SNF benefit -- unfortunately for a very brief period of time due to the repeal of the Act in 1989.

Over time, Medicare has substantially revised payment policy for inpatient hospital admissions, perhaps most notably with regard to those DRGs most likely to result in transfers to post-acute facilities. The current notice of proposed rulemaking for hospital inpatient payments proposes a significant expansion in the “transfer DRG” policy, increasing the number of DRGs subject to reduced payment for short-stays that result in post acute care from the current 29 DRGs to 231 DRGs.<sup>29</sup> In 2003, there were .9 million discharges from the 29 hospital “transfer DRGs” to SNFs. If the 231 proposed hospital “transfer DRGs” had been in effect in 2003, the number of hospital transfer DRG discharges to SNFs would have increased by .7 million, to a total of 1.6 million.

Medicare payment rates for SNFs are substantially lower than payment rates for Inpatient Rehabilitation Facilities (IRFs) or Long Term Care Hospitals (LTCH). In a recent report (*Medicare: More Specific Criteria needed to Classify Inpatient Rehabilitation Facilities*, April 2005), the Government Accountability Office (GAO) found:

“Medicare pays for treatment in an IRF at a higher rate than it pays for treatment in other settings.”

For 2006, projected average payments per admission for IRFs and LTCHs range from over 1.5 to over 3.5 times higher than SNF costs. Unlike discharges from hospital to SNFs, neither IRFs nor LTCHs are subject to the 3 day stay requirement. In 2003, using the 29 DRG hospital “transfer DRG” policy, there were .25 million discharges to IRFs. According to the GAO report, many of the .IRF discharges could have been treated at lower cost – resulting in savings to Medicare – by being admitted to SNFs rather than IRFs (or LTCHs).

The asymmetrical requirement – whereby Medicare covered admissions to the more expensive IRFs and LTCHs are not subject to the arbitrary and outmoded three-day hospital stay requirement but Medicare covered admissions to SNFs are subject to the three-day stay rule – distorts incentives and interferes with the most appropriate and cost-effective placement of Medicare beneficiaries who need post-acute care..

## ***2. Need For A CMS Demonstration Addressing Cost Issues Of 3-Day Stay Elimination***

As indicated above, CMS’ reluctance to address elimination of the 3-day stay requirement may stem from concerns about cost, an incomplete understanding of the gains for Medicare beneficiaries that would result from modifying the three-day stay requirement, and an absence of objective data. This, at a minimum, CMS should initiate a demonstration to evaluate the implications of selectively eliminating the three-day inpatient hospital stay requirement

In conjunction with the new proposed hospital transfer DRG policy, AHCA proposes that CMS test on a nationwide basis, for a time-limited period, eliminating the three-day stay requirement only for those DRGs subject to the transfer payment policy. CMS should conduct a rigorous evaluation of the effects of this demonstration. Based on the results of the demonstration, be reinstated if CMS determines that net federal spending – including Medicaid spending on long term care – increased as a result of the demonstration. If the Secretary determines that the demonstration was not budget neutral, the 3-day stay requirement could be reinstated but the Secretary could nevertheless determine that the gains in patient quality and satisfaction were sufficient to justify further consideration of selective elimination of the 3-day stay. If the results

<sup>29</sup> 70 FR 23306, May 4, 2005

of the evaluation were to show that the demonstration was budget neutral for the federal government, the Secretary could extend the elimination of the requirement beyond the transfer DRGs.

**Concurrent Therapy**

CMS has invited comment on the most effective way to prevent the abuse of concurrent therapy, and to ensure that it is performed only in those instances where it is clinically justified. CMS has acknowledged that concurrent therapy can have a legitimate place in the spectrum of care options available to therapists treating Medicare beneficiaries, as long as its use is driven by valid clinical considerations.

Manor Care strongly believes that any new rules authorizing or limiting Medicare coverage of concurrent therapy must be clear enough to guide the SNF as to what is permitted and what is prohibited. While the preamble broadly discusses concurrent therapy, it does not give notice as to what specific practices might be permitted or prohibited. It lacks precise definition of needed terms, such as “group therapy,” “concurrent therapy,” “services that can be safely and effectively performed only by a qualified physical therapist or under his supervision,” “level of complexity and sophistication,” “accepted standards of medical practice,” “valid clinical considerations,” etc. CMS’ implementation of administrative limitations on levels of supervision, the use of students, and the limitations of group therapy have had a significant impact on the clinical aspects of therapy but have not been given an adequate legal foundation in the regulations.

Manor Care believes that the development and issuance of new policies affecting concurrent therapy, especially policies that would cut back on existing approved coverage policies for Medicare payment, should not be based on imprecise and indistinct generalized discussions in preambles and manuals. CMS’ apparent approach of “regulating by preamble” would be in conflict with the rulemaking provisions of the Social Security Act and the Administrative Procedure Act and with the obligations of notice and comment rulemaking. CMS must conform in this respect to the rulemaking provisions of the Medicare statute.<sup>30</sup> This can only be accomplished by the issuance of precise definitions and payment rules proposed in the Federal Register for public comment before being adopted and put into effect.

**“Concurrent therapy” includes covered services.** The first concern of Manor Care is that the term “concurrent therapy” is not a term with a universally understood definition. The preamble makes an informal attempt at a definition, suggesting that “concurrent therapy” refers to:

The practice of one professional therapist treating more than one Medicare beneficiary at a time -- in some cases, many more than one individual at a time.<sup>31</sup>

<sup>30</sup> Section 1871(a)(2) and (b)(1) of the Social Security Act

<sup>31</sup> 66 Federal Register 23991-92.

The problem with this ambiguous language is that it covers both the “permitted” and the “prohibited.” Practitioners and providers can envision a scenario where professional supervision is so lax as to fail to meet regulatory minimums. However, under the preamble’s definition, there is no inherent inconsistency between what CMS has termed “concurrent therapy” and skilled therapy. By CMS’ own reckoning, the expression “concurrent therapy” would include the “overlap in the time of concluding treatment to one individual and the time of commencing the treatment of another, even to the point of briefly providing therapy concurrently in certain cases,” a practice that the preamble acknowledges is allowed.<sup>32</sup> With the use of such contradictory language, CMS could not reasonably expect providers and practitioners to understand what Medicare prohibits, and what it permits.

Based on existing regulations, CMS is charged with the duty to determine whether therapy services meet the above coverage criteria. The only other legal basis for denying payment for therapy services is the “reasonable and necessary” requirement: the Act excludes even otherwise covered services unless the services are:

... reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.<sup>33</sup>

The significance of the above discussion is to highlight the legal limitations on CMS’ ability to proscribe the therapy benefit. That is, CMS may determine whether services meet the coverage criteria in the regulations and then evaluate whether those services are “reasonable and necessary.” CMS cannot without formal rulemaking impose new or additional criteria for excluding therapy services from coverage.

The interpretive guidelines formerly in §230.3 of the Skilled Nursing Facility Manual set forth only four criteria for judging whether a therapy claim is reasonable and necessary.

Reasonable and Necessary. --To be considered reasonable and necessary the following conditions must be met:

The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient’s condition,

The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision . . . .

There must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the

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<sup>32</sup> **Id.**  
<sup>33</sup> **§1862(a)(1)(A) of the Social Security Act, 42 U.S.C. §1395y(a)(1)(A).**

patient's restoration potential after any needed consultation with the qualified physical therapist or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state, and

The amount, frequency, and duration of the services must be reasonable. (Emphasis added.)

It is not clear to us how a concurrent therapy limitation on the coverage of therapy services can be adopted without doing violence to CMS' long standing definition of covered therapy services. Any approach to limiting current Medicare payments for covered therapy services when they constitute "concurrent therapy" must be clearly defined, easy to administer, and adopted only after notice and comment rulemaking procedures. Manor Care believes that the professional judgment of the licensed therapist should continued to be relied upon to assure that the services provided meet the definition of skilled therapy and the reasonable and necessary requirement is met, and CMS should not limit the clinical approaches available to meet these requirements.

**Pay-For-Performance**

CMS states that pay for performance is a tool that could provide additional support to improve the quality of care provided nursing homes but indicates that development of such a tool raises many complex issues. Manor Care recognizes that the design of a pay for performance system for SNFs involves addressing such issues as, how best to measure performance, what measures currently exist and have the potential to be used for pay-for-performance programs, what measures need to be developed, how best to risk-adjust measures if needed, and the burden placed on providers from collecting data.

While we are strongly in support of a pay for performance approach, it is critical however, that all stakeholders participate in the design of such an approach to assure that the necessary incentives are in place to guarantee that the goals of maintaining and improving quality of care can be accomplished in a reasonable and consistent manner.

**Development of An Integrated Approach to Payment and Delivery of Post Acute Care**

Manor Care supports Medicare payment and delivery system changes that ensure the most appropriate placement for Medicare beneficiaries needing post-acute care. Such system improvements should include implementing a uniform patient assessment instrument for post-acute care settings and ensuring that financial incentives result in the best clinical post-acute placement for patients. Such an integrated payment system must be patient-centric, i.e., based solidly on patient characteristics and outcomes, and be based on a common patient-centered quality assessment system.

We agree with CMS' conclusion that improved information technology is critical for the post-acute and long term care systems and strongly agrees that today and in the future there should be requirements for information exchange among long term care settings (i.e., skilled nursing facilities and other post-acute care settings, assisted living settings, home health care, and independent living settings) acute care and ambulatory care settings that would support a unified post-acute care PPS. CMS should not only promote the use of technology but also look for ways to provide financial support and incentives to providers in order to move this forward.

We believe that through a strong partnership between all stakeholders, that improvements in quality of care, financial stability for both providers and the Medicare Program and meeting the needs of the growing numbers of individuals requiring long term care services can be accomplished. The post acute delivery system has continued to evolve and the approaches to the payment for services must as well.

Manor Care appreciates the opportunity to comment on the CMS proposed rule as well as the open and productive dialogue with both you and the CMS staff regarding not only the issues addressed in the proposed rule but all aspects of the delivery of post acute and long term care services.

Sincerely,  
Manor Care, Inc.

*M. Keith Weikel*

M. Keith Weikel, Ph.D.  
Senior Executive Vice President and  
Chief Operating Officer

**Submitter :** Sarah Pitluck  
**Organization :** Genentech, Inc.  
**Category :** Drug Industry

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please see attached Word document. Thank you.

CMS-1282-P-55-Attach-1.DOC

payment amount.<sup>1</sup> However, in subsequent legislation, Congress also recognized that a number of high-cost services not administered frequently in SNFs could have “devastating financial impacts” for these facilities because the cost of such services may greatly exceed the SNF’s consolidated payment under the PPS.<sup>2</sup> By statute, such services are excluded from CB and are separately billable to a Medicare Part B carrier. Specifically, in Section 103 of the Balanced Budget Refinement Act of 1999 (BBRA), Congress identified a number of items and services within four categories—chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices—to be excluded from the list of services paid to the SNF under the PPS.<sup>3</sup> CMS updates the list of HCPCS codes that are subject to the CB provision of the SNF PPS on a quarterly basis, as needed, when temporary HCPCS codes are released. An update also is released annually to include new permanent HCPCS codes.

Section 103 of the BBRA also gives the Secretary “the authority to designate additional, individual services for exclusions within each of the specified service categories.”<sup>4</sup> In CMS’ final rule of July 31, 2000, the Agency indicates that any additional item or service (identified by HCPCS code) that it might designate for exclusion from the SNF consolidated billing list must: (a) fall within one of the four service categories specified in the BBRA; and (b) meet the same standards of high cost and low probability in the SNF setting.<sup>5</sup> CMS has interpreted its statutory authority to revise the list of codes on the SNF consolidated billing exceptions list in “response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice).”<sup>6</sup> Genentech supports this interpretation of CMS’ statutory authority and encourages the Agency to use it to ensure Medicare beneficiaries’ access to important therapies is not jeopardized in the SNF setting.

### **HCPCS J9035, *Bevacizumab 10mg*, Should Be Added to SNF CB Exceptions List**

Genentech is particularly concerned that HCPCS code J9035, *Injection, Bevacizumab, per 10mg*, used to describe our chemotherapeutic product, Avastin™, is not listed on the SNF CB exceptions list. Avastin™ is the first anti-angiogenic clinically proven to extend survival for first-line treatment of metastatic colorectal cancer, a condition that affects a significant population of Medicare beneficiaries.<sup>7</sup> According to

<sup>1</sup> Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4432(b), Social Security Act (SSA), Section 1888(e)(2)(A)(ii).

<sup>2</sup> BBRA Conference report indicates high-cost, low probability services are those “not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer.” (H.R. Conference Report No. 106—479 at 854.)

<sup>3</sup> Chemotherapy items (identified as of July 1, 1999, by HCPCS codes J9000-J9020; J9040-J9151, J9170-J9185; J9200-J9201; J9206-J9208; J9211; J9230-J9245; and J9265-J9600, and as subsequently modified by the Secretary...) (SSA, Section 1888(e)(2)(A)(iii)(II)).

<sup>4</sup> Balanced Budget Refinement Act of 1999 (BBRA), Public Law 106-113, Section 113, Appendix F, SSA, Section 1888(e)(2)(A)(iii).

<sup>5</sup> 65 *Federal Register* 46790.

<sup>6</sup> 65 *Federal Register* 46791.

<sup>7</sup> [www.avastin.com](http://www.avastin.com). Accessed June 20, 2005.

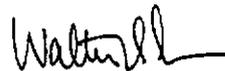
internal sales data, approximately 0.04 percent of Avastin™ sales occur in the SNF.<sup>8</sup> Because Avastin™ is a newly developed biologic, the cost of treatment with the product may deter use in SNFs. Genentech believes that Avastin™ is exactly the type of product Congress intended to exclude from the SNF CB exceptions list.

In addition, other chemotherapeutic products, particularly those for the treatment of colorectal cancer, are listed on the SNF CB exceptions list. Specifically, J9055, *Injection, Cetuximab, per 10 mg* (Erbix™), is used to shrink and delay tumor growth in some patients with colorectal cancer. No clear reason exists as to why a therapy like J9055 is listed on the SNF CB exceptions list and J9035 is not. As such, Genentech feels strongly that Avastin™ meets the qualifications described above for an item or service to be excluded from the SNF CB list. Genentech urges CMS to add J9035, *Injection, Bevacizumab, per 10mg*, to the list of HCPCS codes excluded from SNF CB in the SNF PPS Final Rule for FY 2006.

### Conclusion

Genentech thanks CMS for the opportunity to submit comments to the consolidated billing section of the SNF PPS FY 2006 proposed rule and urges CMS to fulfill Congressional intent by ensuring that SNF patients have access to needed medical therapies chosen in consultation with their physician. As such, we encourage the Agency to include new high cost, low use chemotherapy products such as J9035, *Bevacizumab, 10 mg*, to the consolidate billings exceptions list to receive separate payment in the SNF setting. Please do not hesitate to contact me directly at (202) 296-7272 if you have any questions about our comments or need additional information.

Sincerely,



Walter Moore  
Vice President, Government Affairs  
Genentech, Inc.

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<sup>8</sup> Percentage based on Genentech sales data from January 2005 through June 2005.

**CMS-1282-P-56**

**Submitter :** Mr. Keith Goss  
**Organization :** Life Care Centers of America, Inc.  
**Category :** Long-term Care

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1282-P-56-Attach-1.PDF



3001 Keith Street, NW / P.O. Box 3480 / Cleveland, Tennessee 37320-3480  
(423) 472-9585 / WWW.LCCA.COM

July 11, 2005

Mark McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
File Code: CMS-1282-P  
Room 445-G Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

Re: Comments on Prospective Payment System and Consolidated Billing for Skilled  
Nursing Facilities for FY 2006  
File Code CMS-1282-P

Dear Dr. McClellan:

Life Care Centers of America, Inc. (LCCA) appreciates the opportunity to comment on the proposed rule: *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006* that was published in the May 19, 2005 Federal Register. LCCA and its affiliated entities own and / or manage over 220 Skilled Nursing Facilities (SNFs) located in 28 states. Our comments pertaining to the Centers for Medicare & Medicaid Services (CMS) proposed rule follow.

#### **General Comments**

LCCA and other companies like it provide care to thousands of residents each day, most of which are our oldest and most frail citizens. A majority of these residents rely upon Medicare and Medicaid to fund their care. It is very important to the long-term care industry to maintain a stable, appropriate funding level. Many researchers have documented significant shortfalls in state Medicaid funding of long-term care. In fact the average Medicaid payment rate in many states is less than the amount someone would pay for a mid-priced hotel room. However, unlike the hotel, which only provides a room and basic housekeeping services, SNFs provide around the clock nursing care, housekeeping, meals, laundry, ancillary services, social services, activities, and many

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Mark McClellan, M.D., Ph.D.

July 11, 2005

Page 2

other services. The long-term care industry has been able to supplement Medicaid shortfalls via funding from other sources. The primary source of other funding has been the Medicare program.

The proposed rule noted above eliminates temporary add-ons to the SNF Medicare rates that have been in place since April 1, 2000. The elimination of funding provided by these add-ons could have a devastating impact on the long-term care industry. Fortunately, CMS' proposed rule provides for a 3% market basket increase on October 1, 2005 and another 3% payment increase on January 1, 2006 to account for the variability of non-therapy ancillary cost. According to the proposed rule and press releases distributed by CMS, these proposed changes – market basket increase, increase for variability of non-therapy ancillary cost, and elimination of add-ons – are an offset and Medicare SNF payments will remain the same. This would be great news for the long-term care industry, as the threat of drastic Medicare cuts by eliminating the add-ons has created uncertainty and apprehension in the industry. However, as explained later, the published Medicare rates that are to be effective January 1, 2006 will cause a significant reduction in Medicare payments. **We estimate payments based on the published rates will reduce annual Medicare funding to SNFs by over \$500 million.** Hopefully corrected rates will be issued that will achieve CMS' goal of eliminating the add-ons while maintaining funding at current levels.

#### **Proposed Refinements to the Case Mix Classification System**

CMS published proposed SNF Medicare payment rates for the revised RUG 53 system that are to be effective January 1, 2006 in the May 19, 2005 Federal Register. Since that time we know of at least two revisions that have been released, with the latest revision we know of being available on CMS' website on June 28, 2005. Our analysis of RUG 53 rates released with the May 19, 2005 Federal Register showed the nursing case mix indices appeared to be calculated incorrectly while the therapy indices seemed appropriate. The first revision, which we understand was circulated to provider trade organizations, seemed to correct the nursing case mix indices, but appeared to have flaws in the therapy indices. Finally, our analyses of the rates that were made available via CMS's website on June 28, 2005 show that both the nursing case mix and therapy case mix indices appear to be misstated. The details provided below will focus on the latest SNF Medicare payment rates released by CMS – those that were posted on the website on June 28.

In regards to the nursing case mix indices, the May 19 proposed rule indicates the nursing case mix values were redistributed from the 44 RUG categories to 53 RUG categories. Values were then "standardized" to ensure the redistribution did not increase or decrease payments, i.e. the redistribution should result in no impact on payments. Finally, CMS

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Mark McClellan, M.D., Ph.D.

July 11, 2005

Page 3

stated the standardized rates were increased by 8.4% to achieve an overall payment increase of 3%. This overall payment increase was to account for variability in non-therapy ancillary costs.

We agree with this theory and commend CMS for the increase in rates to help providers cope with the variability of non-therapy ancillary cost. However, we believe the nursing indices CMS posted on June 28 are understated. The following describes how we arrived at our conclusion:

- We calculated the average nursing case mix index based on the current nursing case mix indices to be 1.0874. We used the "2001 Distribution of RUG Days" posted on CMS' website in our calculation. We multiplied the days for each RUG category by the current case mix value assigned to each RUG category. We totaled these amounts and divided by the total Medicare days to arrive at the average nursing case mix.
- When the case mix values are redistributed to the 53 RUG categories, a calculation should be made to "standardize" the case mix indices. After this calculation to "standardize" the case mix values, the average nursing case mix under the RUG 53 system should be the same as the average nursing case mix calculated using the RUG 44 system – which is 1.0874.
- Increasing each nursing case mix value by 8.4% (to achieve a 3% increase in overall payments) would yield an average nursing case mix of 1.1787 (multiply the average nursing case mix of 1.0874 by 1.084).
- Our next step was to calculate the average nursing case mix based on the nursing case mix indices shown on CMS' payment rates released on June 28. The average nursing case mix calculated using these nursing indices was only 1.1212 – which is considerably less than the 1.1787 average nursing case mix we calculated in the previous step.

We also have concerns about the therapy case mix index values shown on the most recent rate sheets published by CMS. The addition of the nine rehab RUG categories to create the RUG 53 system was to provide a more appropriate payment for the nursing services provided to those residents who were receiving rehab, but were also receiving nursing services at a level that would allow the resident to classify into an extensive services RUG category. There should be no difference between the rehab services provided to a resident that is classified in a RUX category and a resident classified in a RUC category; nor should there be any difference in the rehab provided to a resident in a RVX category and an RVC category. An "ultra rehab" patient is provided the same service regardless of whether they are in a rehab-ultra-extensive payment category or the original rehab-ultra payment category. However, CMS' most recent rate sheets show differences in the therapy index values for the various rehab groupings. For example, the rehab-ultra-

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Mark McClellan, M.D., Ph.D.  
July 11, 2005  
Page 4

extensive payment category has a therapy index value of 2.46 while a rehab-ultra payment category has a therapy index value of 2.20.

**Summary**

We commend CMS for their intentions on removing the temporary add-ons while maintaining SNF Medicare payments at the current funding level. The significant negative impact on Medicare funding resulting from the potential removal of the payment add-ons has been a detriment to the long-term care industry for several years. Our industry would greatly benefit from stability in Medicare funding and payment policies. While we applaud CMS' intentions, as we previously noted, we believe the RUG 53 payment rates published by CMS result in a significant reduction in Medicare SNF funding that would be very harmful to the long-term care industry. We encourage CMS to review their payment calculations and provide details so that interested parties can readily verify the calculations.

Thank you for allowing us to comment on this proposed rule. Please contact me if you have any questions or comments.

Sincerely,



Keith Goss  
Senior Vice President of Reimbursement

/kjc

**Submitter :** Ms. Barbara Marone  
**Organization :** American College of Emergency Physicians  
**Category :** Health Care Professional or Association

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

SEE ATTACHMENT. A return acknowledgement of the electronic comments. Thank you.

**Issue**

SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

Please see the attached file. A return acknowledgement of the electronic comments would be greatly appreciated. Thank you.

*No attachment*

CMS-1282-P-59

**Submitter :**

**Date: 07/11/2005**

**Organization :**

**Category : Long-term Care**

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1282-P-59-Attach-1.DOC

July 11, 2005

Centers for Medicare and Medicaid Services  
Attention: CMS-1282-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Dear Sir or Madam:

Thank you for the opportunity to comment on the Proposed Nursing Home Payment Reforms Increase Accuracy, Predictability of Payment published on May 13, 2005. Life Care Centers of America, Inc., is a privately owned company which operates nursing and retirement centers in 28 states. These comments were developed from our associates and management staff.

***Proposed Refinements to the Case-Mix Classification System***

**Services furnished during the preadmission period reflected on the MDS (P1a – IV medications, suctioning, tracheostomy care, ventilator/respirator)**

We are concerned that removal of the preadmission look-back period would be detrimental to beneficiary care. Two of the primary purposes of the current assessment system are to provide the facility with a picture of its beneficiaries' functional capabilities and help staff identify health problems. Changing the current practice of including the services listed above in the 14-day look-back period would make it more difficult for the SNF to identify an unstable and intensive condition that frequently follows these types of services. Our concern increases significantly if the other services currently included in P1a (Special Care) are also excluded from the 14-day look-back period. These services are chemotherapy, dialysis, oxygen therapy, radiation and transfusions.

Beneficiaries who have recently received these types of service frequently require a high level of skilled nursing services for some time. We suggest it is appropriate to consider the high level of nursing resources needed when determining the correct RUG level for these beneficiaries.

***Proposed Refinements to the Case-Mix Classification System***

**Grace day period associated with all PPS assessments**

Grace days provide nursing staff more flexibility in setting the assessment reference date. At times this will provide the SNF the needed discretion to reallocate nursing resources to direct beneficiary care. The RAI manual succinctly states our concern on page 2-28: "Grace days can be added to the Assessment Reference Date in situations such as an absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture

therapy minutes or other treatments. The use of grace days allows clinical flexibility in setting ARDs, and should be used sparingly." The paperwork requirements continue to increase and flexibility with setting the ARD can often provide the facility with additional nursing time for beneficiary care. While we suggest that this is a valid concern for all the required PPS assessments, the most significant impact is with the limited assessment reference date of the 5-day assessment.

***Proposed Refinements to the Case-Mix Classification System***

**Grace day period for the 5 day MDS**

The PPS final rule indicates several valid reasons for allowing grace days for the 5-day assessment. It is our suggestion that these reasons are equally valid today. The following are located in the Federal Register Vol. 64, No. 146, page 41657:

- "to offset any incentive that facilities may have to initiate therapy services before the beneficiary is able to tolerate that level of activity"
- "to minimize incentive to provide too high a level of rehabilitation therapy to newly admitted residents"
- "to make it possible for beneficiaries to classify into the two highest RUG-III rehab categories"

***Proposed Refinements to the Case-Mix Classification System***

**Projection of anticipated therapy services during the 5-day assessment**

Projection of anticipated therapy services "allows the facility to provide the most accurate representation of the services to be provided to the beneficiary during the first assessment period." (Federal Register Vol. 64, No. 146, page 41662) In the absence of the clinician's ability to project, many beneficiaries would be placed into lower than appropriate groups. When an inappropriately lower therapy group occurs too frequently, the SNF will be placed in a difficult financial situation.

***Proposed Refinements to the Case-Mix Classification System***

**Grace day period and projection of anticipated therapy for the 5-day MDS**

Elimination of both grace days on the 5-day MDS and anticipated therapy services would put a significant financial strain on SNFs. Without at least one of the current methods of accurately capturing needed therapy services on the 5-day assessment, SNFs will be consistently underpaid for the first 14 days of a beneficiary's stay. Specifically, it would be impossible for any beneficiary to qualify for a rehab low category since 6 days of restorative nursing are required. Further, many residents are not able to participate with therapy during the first few days after admission. Therefore, it would be unlikely that a beneficiary would be able to receive the required 5 days of therapy treatment to qualify for rehab medium, high, very high, or ultra.

Therapy is vitally important to the health of many beneficiaries; however, it is an expensive service to provide. Prolonged underpayment during the first 14 days obviously

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would create an environment of risk to the beneficiary by either pushing the beneficiary to participate with therapy before physically able or by reducing the therapy provided to match the reimbursement. Either of these outcomes is unacceptable.

### ***Concurrent therapy***

Concurrent therapy is a needed option for beneficiaries to receive appropriate care. Therefore, we strongly discourage consideration to eliminate concurrent therapy. We suggest that the current methods of medical review by intermediaries and contractors are sufficient to identify and correct any abuse of concurrent therapy.

The beneficiaries receive a number of advantages with concurrent therapy. For example:

- Beneficiaries in the midst of planned and necessary rest breaks are encouraged and motivated by activity of other beneficiaries.
- Beneficiaries increase functional outcomes by facilitating socialization skills.
- Beneficiaries are encouraged to maximum independence while still receiving necessary supervision.

### ***Federal Rate Update Factor***

#### **Consolidated Billing–**

The list below contains several medications that currently are not considered “exclusions”. However, the physician in some situations orders these, and the cost can be detrimental to the facility. We recommend the following medications be added to the exclusions.

1. HCPCS Q4053 (Neulasta/Pegfilgrastin) – Chemo Medication
2. HCPCS Q4077 (Treprostinil/Remodulin) – Medication for Pulmonary Artery Hypertension
3. HCPCS J2324 (Natrecor) – Chemo Medication
4. HCPCS Q0137 (Darbepoetin alfa, non ESRD) – Chemo Medication
5. HCPCS J9260 (Methotrexate sodium inj) – Chemo Medication
6. HCPCS J1950 (Leuprolide acetate) – Chemo Medication
7. No HCPCS assigned as of yet for Thalidomide – Chemo Medication

### ***Federal Rate Update Factor***

#### **Qualifying Three-Day Inpatient Hospital Stay Requirement to include Observation Overnight Stays**

We suggest that a beneficiary who has spent three overnights in a hospital, regardless of their status as either inpatient or observation/outpatient, should be allowed to utilize their Part A benefits for the following reasons:

1. In certain areas of the country, beneficiaries are often left overnight in hallways or multiple nights in the emergency/triage areas due to the population growth and bed shortages in expansion areas.
2. In most cases, a beneficiary’s condition requiring three consecutive overnights in a hospital setting will also require, at a minimum, observation and assessment in the SNF setting.

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3. An elderly beneficiary, who has spent three overnights in a hospital bed, is at risk for DVT, muscle weakness, continence issues, skin issues, etc., that often require at a minimum, skilled observation services.

4. The beneficiary's functional abilities have possibly deteriorated secondary to being in a lying position for three days and often require therapy (skilled) services afterwards to return to prior level of function.

Also important to consider is that a beneficiary and his/her family often do not understand the difference between being an inpatient and being an observation patient. As a result, the beneficiary frequently assumes any three days in the hospital meets the three-day requirement. While this is explained to the beneficiary and family, admittance into a SNF is a difficult time and this type of confusion makes it even more difficult for the beneficiary.

Again, we thank you for the opportunity to comment on the Proposed Nursing Home Payment Reforms Increase Accuracy, Predictability of Payment published on May 13, 2005. If you have questions regarding any of our comments, contact us at the telephone numbers below.

Sincerely,

Kristie Brown, RN  
Director of Medicare Support Services  
Life Care Centers of America  
(423) 473-5565

Charlene Allen  
Director of Medicare Claims  
Life Care Centers of America  
(423) 473-5751

**Submitter :** Ms. Barbara Marone  
**Organization :** American College of Emergency Physicians  
**Category :** Health Care Professional or Association

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

SEE ATTACHMENT

**Issue**

SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists

July 8, 2005 Attention: CMS?1282-P

Mark B. McClellan, MD, Ph.D. Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

REF: CMS?1282?P: Medicare Program: Prospective payment and Consolidated Billing for Skilled Nursing Facilities for FY 2006

Dear Dr. McClellan:

On behalf of the American College of Emergency Physicians (ACEP), I am pleased to submit comments on the proposed rule on skilled nursing facility payment. ACEP is a national medical specialty society with more than 23,000 members, dedicated to improving the quality of emergency care through continuing education, research, and public education. We appreciate the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our comments on the three-day hospital stay rule.

**Qualifying 3-day Inpatient Hospital Stay for SNF Coverage**

We strongly urge CMS to revise its interpretation of the 3-day inpatient stay requirement for Medicare SNF coverage to include observation status time (24-48 hours) preceding a patient's formal inpatient admission to the hospital.

As stated in the NPRM, "the original Medicare legislation required that a beneficiary must first be a hospital inpatient for 'not less than 3 consecutive days before his discharge from the hospital to a skilled nursing facility.' It is important to note that this requirement for Medicare SNF coverage was created in 1965. Since then, the services that are provided under observation status have been refined and advanced. Clinical observation services provided in EDs and a significant number of dedicated observation units provide inpatient level care in less than one day that had previously taken 2 to 3 days as a hospital inpatient. In our view, the 3-day requirement is intended to reflect services that are comparable to the level of care provided to inpatients. Current observation services provide this level of care.

Much of a patient's work up and intensity of services occurs during the emergency department stay. For example, a hospital admission for chest pain five to ten years ago that may have required a 2-3 day hospital stay is now evaluated and dispositioned within 24 hours or less. Further, patients in observation receive physician evaluation and management services similar to what they receive when hospitalized. If a patient fails active observation care and requires admission, the subsequent inpatient care is actually an extension of the hospital level of care provided in observation.

ACEP is concerned with CMS' attempt to pre-empt comments that would reconcile section 1886(a) with section 1861(i). We understand that under current payment rules, when Medicare patients who come to the ED are admitted, hospitals cannot bill Medicare for the ED (facility) visit as these costs are folded into (considered part of) the inpatient

McClellan Letter ? SNF

July 8, 2005

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stay costs. CMS goes on to argue that in spite of these costs being shifted to the inpatient side of the "ledger", the time the beneficiary spends receiving those services (for purposes of the 3-day stay rule), continues to be counted on the outpatient side.

This rigid interpretation of "inpatient" for a hospital qualifying stay appears to be entirely driven by perceived costs of a more flexible application. Under current regulations, only three diagnoses/conditions are separately paid to hospitals under the Medicare Outpatient Payment system, so concerns about additional expenditures for observation care may not be valid. In addition, with CMS considering adding more inpatient diagnoses under transfer rule payment status, additional savings can be recouped on the inpatient side.

Finally, there appears no appreciation in this interpretation for the appropriate needs of the beneficiary, even within the context of the statutory requirement.

**Submitter :** Mr. Brian Schoeneck  
**Organization :** Wisconsin Association of Homes and Services  
**Category :** Health Care Provider/Association

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

"See Attachment for comments on Identifier IV - Consolidated Billing for Skilled Nursing Facilities

CMS-1282-P-62-Attach-1.DOC

CMS-1282-P-62-Attach-2.DOC

CMS-1282-P-62-Attach-3.TXT

**Wisconsin Association of Homes and Services for the Aging, Inc.**

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204 South Hamilton Street • Madison, WI 53703 • 608-255-7060 • FAX 608-255-7064 •  
www.wahsa.org

July 11, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1282-P

**Issue Identifier IV. – Consolidated Billing for Skilled Nursing Facilities**

Please consider the following drugs and treatments for consolidated billing exclusions. In many instances, the cost of the drugs and treatments far exceed the payments received under the Medicare prospective payment system.

**Examples of expensive drugs:**

Epogen and Procrit: These drugs when given in units cost \$666.89 for 10,000 units, \$1,333.78 for 20,000 units, and \$1,778.37 for 40,000 units.

Neulasta (Pegfilgrastin) (J 2505): This drug costs \$2,507.50 for 6mg.

Neupogen: This drug cost \$1,795 for 300 ml and \$2,860 for 480 ml.

Lupron: This drug cost \$465.50 for 3.75 mg and up to \$2,239.97 for 30 mg.

Forteo: This drug costs \$700 for 12 days.

**Examples of expensive injections:**

Epogen and Procrit Injection: \$100.00 per Day.

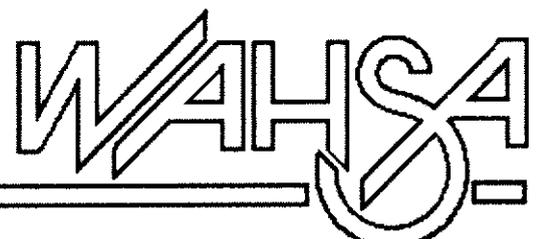
Fragmin and Lovenox Injection: \$100.00 per Day.

Rebif Injection: \$60.00 per Day.

Arixtra Injection: \$44.00 per Day.

Avonex Injection: \$40.00 per Day.

TPN-Total Parenteral Nutrition: Nursing Facilities pay between \$150 and \$250 per day depending on the drugs ordered and requires substantial RN time.

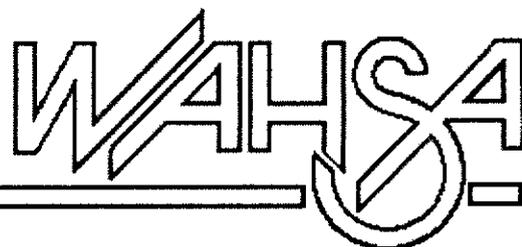


**Arguments for Consolidated Billing Exclusions: Examples of High Cost Medicare Part A Residents:**

1. Resident A received a Lupron cancer injection at the physician's office. This injection is not a specifically excluded cancer drug. The physician office billed the NF the amount they would have been paid by Part B or \$633.91 (Code J9217).
2. Resident B receives IV Antibiotics for 20 days. The cost to the NF for the IV solution was \$3,290 or \$165.00 per day.
3. Resident C has an extensive list of medical problems and suffers from end-stage renal disease. Medications for the resident include voriconazole, acyclovir, tamsulosin, bactrim, norvasc and calcitriol. The resident's medications cost approximately \$4,500 per month. Therapy costs for five days per week cost exceed \$3,200 per month. Medicare funds are inadequate to cover the expenses for medications, therapy, nursing labor and room and board.
4. Resident D has multiple medical diagnosis including multiple myeloma, end-stage renal disease, pleural effusion, sepsis and depression. The resident also is a hemodialysis patient. The resident receives daily antibiotics at a cost of \$63 per dose and receives multiple injections. The resident receives Procrit weekly which costs \$500 per dose. The resident also receives Lovenox daily at a cost of \$25 per dose. Multiple labs are drawn on a regular basis in relation to the types of medications and these lab costs are also part of the Medicare daily rates. The resident also requires expensive wound care supplies to treat stage IV bilateral heel necrosis.

Thank you for the opportunity to respond to the proposed rule for the prospective payment system and consolidated billing for skilled nursing facilities for FY 2006. Please consider these comments when considering additional drugs and treatments for exclusion under consolidated billing.

Brian Schoeneck  
Financial Services Director



62-6

Wisconsin Association of Homes and Services for the Aging, Inc.

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204 South Hamilton Street • Madison, WI 53703 • 608-255-7060 • FAX 608-255-7064 •  
www.wahsa.org

July 11, 2005

Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1282-P

Issue Identifier IV. – Consolidated Billing for Skilled Nursing Facilities

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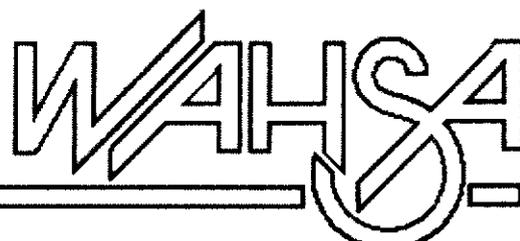
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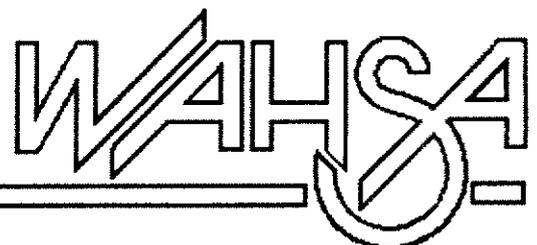
62-e

**Arguments for Consolidated Billing Exclusions: Examples of High Cost Medicare Part A Residents:**

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Thank you for the opportunity to respond to the proposed rule for the prospective payment system and consolidated billing for skilled nursing facilities for FY 2006. Please consider these comments when considering additional drugs and treatments for exclusion under consolidated billing.

Brian Schoeneck  
Financial Services Director



**Submitter :** Ms. Brian Schoeneck  
**Organization :** WI Association of Homes & Services for the aging  
**Category :** Health Care Provider/Association

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

sec attachment

CMS-1282-P-63-Attach-1.DOC

CMS-1282-P-63-Attach-2.DOC

**Submitter :**

**Date:** 07/11/2005

**Organization :**

**Category :** Long-term Care

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1282-P-64-Attach-1.DOC

*form letter*

**HILLVIEW TERRACE**  
***RehabSelect***  
100 Perry Hill Road  
Montgomery, AL 36109

July 8, 2005

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
ATTN: File Code CMS-1282-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

We appreciate the opportunity to comment on the proposed rule to update the payment rates in the Medicare Skilled Nursing Facility (SNF) Prospective Payment System (PPS) for the 2006 fiscal year and implement refinements in the RUG-III case-mix classification system, published in the May 19, 2005, *Federal Register*.

Hillview Terrace is a 143 bed skilled nursing facility located in Montgomery, AL. We provide not only skilled nursing services but comprehensive rehabilitative services as well. We average 15% of our population as Medicare part A recipients and are the only facility located on the east side of Montgomery.

The following comments are relative to "Proposed Refinements to the Case-Mix Classification System." The comments herein are specific to the proposed possible modifications to the Resident Assessment Instrument (RAI) Manual. We have significant concerns about each of the potential modifications to the current system including the look-back period, the use of grace days and projecting therapy minutes. The elimination of the look-back period, grace days and estimated therapy minutes from the RAI Manual will negatively affect the quality of services to the most acutely ill of the nation's SNF patients – the post-acute-stay Medicare-covered patients. It appears the changes could be especially damaging to patients in rural America reducing access to quality SNF services.

We believe the three day qualifying hospital stay requirement should be modified to include observation stay time.

attch 64

### **Look-Back Period**

Elimination of the “look-back” into the hospital stay will reduce access to Medicare benefits for many individuals and reduce payments to SNFs for the most critical portion of the patients’ SNF stay – the initial few days.

The look-back period as it is currently implemented, allows the facility to “look back” into the hospital stay of any Medicare Part A eligible beneficiary to gather certain information pertinent to level of care necessary once the patient has been admitted to the skilled nursing facility. The accumulation of this data is necessary to adequately plan for the provision of the appropriate care (and determine the appropriate RUG group). As stated in the SNF PPS final rule, “the characteristic tendency for a SNF patient’s condition to be at its most unstable and intensive state is at the outset of the SNF stay.” This requires the SNF to commit its greatest amount of resources to the care of the post-acute patient within the first few days after admission to the SNF. The look back allows the SNF to properly analyze the patient’s conditions and develop a plan of treatment that addresses the critical needs of the patient. This is crucial to the patient’s improvement.

As patients transition from IV feeding and IV medications provided in the hospital, the SNF’s nurses must be actively involved to allow the patient’s recovery to progress appropriately or to take action if the transition does not proceed as planned. When the PPS was created, the Medicare program recognized the difficulties involved in the transition and allowed the look-back to acknowledge the required SNF level of care. If the look-back is removed, the SNF will be required to give the same care to the Medicare Part A patient, but will be paid substantially less in many circumstances. This action will reduce the SNF provider’s resources available to provide the quality services expected by the patient and the Medicare program.

The RUG categories that will be affected to the greatest extent will be Extensive Services. It should be a matter of record that the most common defining service during the hospital stay that creates the SE category at the sub-acute level is IV medications. Many Medicare Part A eligible patients, who are admitted to a hospital (either through the ER or with a planned admission), have an IV started in the hospital. By not being able to utilize the look-back period, it appears that patients transferred to skilled nursing facilities will not be able to appropriately utilize one of the proposed new upper nine RUG-53 groups due to the lack of accessible data to properly code the patient into an extensive services level of care along with rehab therapy minutes and activities of daily living.

Many patients are admitted to the SNF mere hours after the IV has been discontinued at the hospital. If the IV was, for example, to deliver chemotherapy, antibiotic therapy, heparin therapy, or blood transfusions, the patient will require a significant level of skilled nursing care

for monitoring and treatment of symptoms associated with the causative medical condition. As it currently stands, the sickest of elderly patients are those in the first week after admission following a hospitalization for infections, chronic disease exacerbations (Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), cancer, etc.) and surgeries. These patients also debilitate quickly under those circumstances and may benefit from rehabilitation services, but often are not able to participate in any meaningful therapy program within the first week to 10 days at the SNF. If the hospital look-back for IV meds is not allowed, it is possible the sickest patients will not have an appropriate RUG pathway to care.

If the look-back is limited to only include those services furnished by a SNF after a patient's admission or re-admission, and eliminates the potential to capture treatments performed by the hospital prior to the SNF admission, overall SNF Medicare expenditures will be reduced. However, we disagree that this reduction in payment would be better aligned with services actually provided.

As noted on page 29076 of the May 19, 2005, proposed rule (section II.B.2.a.), data analysis performed by the Urban Institute "...again verified that non-therapy ancillary costs are higher for Medicare beneficiaries who classify into the Extensive Services category than for those who classify to other categories." CMS's research appears to indicate that a reduction in payment is not warranted because of the correlation between Extensive Services and higher cost. If the look back is eliminated, the number of patients qualifying for Extensive Services is significantly reduced, but the research indicates these patients have higher non-therapy ancillary costs than other categories.

The analysis cited in the proposed rule contends that the addition of nine new categories that combine Rehabilitation and Extensive Services improves the predictive power of the RUG-III model. However, revising the RAI Manual to only include special treatments and procedures furnished by the SNF would significantly reduce the number of residents that would be classified into the Extensive Services category. Adding nine new RUG-III categories that combine Extensive Services with Rehabilitation, when patients would not be able to qualify for Extensive Services, would seem to defeat the purpose of the RUG refinements and undermine the predictive power of the new RUG-53 model because many patients presently qualifying as Extensive Services would not be classified into the new levels (nor the present Extensive Services categories).

### **Decrease or Elimination of the Grace Period**

A reduction or elimination of the grace day period used to set the assessment reference date, specifically for the five-day PPS MDS assessment, would have negative patient care implications.

Used appropriately, grace days allow a SNF to better serve the patient's needs, allowing therapy evaluation and services to be provided to generate the greatest health benefit to the patient and provide appropriate reimbursement to the facility. Grace days allow the evaluation and services to occur according to the clinically best time-frame, rather than requiring an artificial regulation-imposed time-frame for the services.

In the July 30, 1999, final rule CMS stated that the use of grace days may be appropriate, especially in cases when, "the beneficiary is not physically able to begin therapy services until he or she has been in the facility for a few days." The final rule goes on to say that the use of grace days for the five-day MDS "make it possible for beneficiaries to classify into the two highest RUG-III rehabilitation sub-categories. Classification into the Ultra High and Very High Rehabilitation sub-categories is not possible unless the beneficiary receives the sub-category's minimum level of services during the first seven days of the stay." Both of these arguments in favor of the use of grace days remain valid.

When PPS was initially developed, the use of grace days for rehabilitation patients on the five-Day assessment was legitimately expected for a number of reasons associated with both the availability of the therapist and the patient. The reality of the five-Day Assessment, without the use of grace days, is that patients must be evaluated by a licensed professional therapist on the day of admission. In order to achieve any RUG group at a level higher than Rehab Medium, the patient will have to be treated on all of the first five days in the SNF, which includes weekends.

Discharges from the hospital setting are not under the control of the SNF. It is the experience of many SNFs, that many hospitals are prone to discharge patients on Fridays (typically in the afternoon). Regardless of the day of discharge, patients usually arrive at the SNF after 1:00 pm. It is inappropriate to expect the new Medicare Part A patient to be able to tolerate all the assessments required by the SNF nursing and rehabilitation therapy staff within the first few hours of admission to the SNF. The ambulance ride alone, often 30 minutes or more to the SNF (especially in a rural setting), can be a traumatic experience for the patient.

Most patients are not physically able to appropriately participate in an effective rehabilitation therapy evaluation on the afternoon of the admission to the SNF. In many facilities, rehabilitation therapy services are often not available seven days per week, thus patients cannot be evaluated for rehab therapy needs until the Monday following the "common Friday afternoon

admission.” Thus, if grace days are eliminated, the average days that can be included in the assessment reference window for rehab therapy will be two (2). This will inappropriately restrict the Medicare beneficiary’s access to the Medicare Part A covered benefits (especially for rural Medicare Part A patients where therapist availability is even more limited).

The current availability of therapists in most markets will not allow for seven day per week schedules or weekend coverage. Many SNFs do not have sufficient utilization to support a full time therapist, so they must “share” therapists with other providers. The coordination of available therapists with an unpredictable hospital discharge time-table could result in poor coverage and personnel crises, particularly in rural areas.

Elimination of the latitude for a SNF to use grace days on the initial five-day assessment could result in patients whose condition primarily warrants skilled rehabilitation, such as hip fracture or CVA, not even being classified into a rehabilitation category. In the July 1999, SNF PPS final rule, CMS commented their intent was “to minimize the incentive to facilities to provide too high a level of rehabilitation therapy to newly admitted beneficiaries. Having these extra few days allows time for those beneficiaries who need it, to stabilize from the acute care setting and be prepared for the beginning of rehabilitation in the SNF.” Reduction or elimination of the grace days for the five-day PPS MDS assessment creates incentives to prematurely initiate therapy before a resident is physically able to tolerate and benefit from it. The result of accelerated initiation of therapy is reduced improvement in health of the patient, which is not the goal of the patient, CMS, or the SNF. Used appropriately, grace days help improve the quality of services.

Patients are now discharged from the acute level in fewer days, resulting in sicker, less hearty patients at the time of the SNF admission. Often, there is little value in a therapy evaluation taking place in the late afternoon or evening of the first day for a frail, elderly patient who has experienced upheaval, ambulance travel and who is emotionally and physically exhausted. It is not appropriate for a medical system policy to mandate that a patient be required to endure such adverse, and often inappropriate, program requirements. A good clinical model is one that allows patients a day or so to adjust to their new reality and surroundings without compromising their recovery. The use of grace days on the five-Day MDS accomplishes this end. The use of grace days on any assessment should be for the provision of the appropriate clinical program for the patient that results in appropriate reimbursement to the provider. The same reasons exist today which existed in 1997, when the Balanced Budget Act of 1997 created the SNF PPS.

**Elimination of Projected Therapy Minutes**

Elimination of the projection of anticipated therapy services during the five-day PPS assessment could negatively affect the quality of services and the benefits derived by the patients.

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Elimination could result in inappropriate incentives to either provide too much therapy too soon or delay therapy beyond when it would be best initiated for the patient's health.

Elimination of the projection of anticipated therapy services will restrict the SNF's ability to appropriately classify patients into rehabilitation RUG-III categories when their condition clearly warrants the need for therapy services. Often, therapy is not initiated until after the end of the initial assessment, but is provided prior to the 14-day assessment. By allowing a beneficiary to classify into an appropriate RUG-III rehabilitation group based on anticipated receipt of therapy, a SNF can be paid for the therapy services being provided during the first 14 days after admission.

There are legitimate reasons to project a therapy RUG on the five-Day MDS. The ability to do so financially protects a Medicare Part A provider who, in good faith, has assessed the needs of a patient and developed a plan of rehabilitation that is interfered with in unforeseen ways, including *unplanned* discharges prior to the planned five-Day assessment reference date.

Currently, if any unforeseen or uncontrollable issue arises in the first five days of a SNF rehab stay, the only options to maintain a rehab reimbursement category are the use of grace days or projected minutes. If both of these options are eliminated, quality of care becomes an issue for the majority of the SNFs – especially those located in rural communities (due to therapist availability.) Once again, the same circumstances exist now that existed when the SNF PPS payment system was initially created.

By eliminating the ability to capture ordered and scheduled therapy services, there may be a tendency for providers to hasten to provide therapy services prematurely or at a level that is too rigorous for the individual's health status. On the other hand, if starting therapy early is not possible, there may be an incentive to forgo or at least postpone therapy services that could be very beneficial to improving a patient's function. In either case, there is an incentive to schedule the onset of therapy services based upon whether the provider will be paid at a rehabilitation level, rather than what is the most appropriate for the beneficiary's care.

We realize there may be situations where estimated therapy minutes have been overstated, resulting in higher than appropriate therapy minutes allocation and potentially higher rehabilitation RUG categories. However, these cases should be handled the same way all inappropriate coding errors are addressed.

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### **Qualifying Three-Day Inpatient Hospital Stay Requirement**

We believe observation days should be counted toward the technical three-day acute care stay requirement for eligibility for skilled care.

As noted by CMS, the care furnished during a hospital observation period is frequently undistinguishable from the care provided after a Medicare patient has been admitted to an acute care bed.

In a case where a hospital admits a patient for observation and that patient is ultimately admitted to acute care but is discharged prior to the third "acute" day, the patient could be deprived of their SNF benefit merely because the hospital was judicious in observing a patient to ensure admission to acute care was warranted.

Allowing observation days to count toward the required three-day hospital stay will require a change to the "Common Working File" (CWF), because even though hospitals are required to "bundle" observation services with inpatient services, the formal acute admission date (not the date the patient is admitted for observation) is the date reported on the hospital's claim, which is ultimately recorded in the CWF as the actual admission date. There would need to be some mechanism to distinguish acute hospital stays that are actually less than three days from those that would be (at least) three days by allowing observation days, in determining whether there has actually been a qualifying hospital stay.

Since the implementation of SNF PPS, there have been situations when SNFs have inadvertently counted an observation stay period as a part of an acute care inpatient admission, resulting in a non-qualifying three midnight acute care period. Counting observation midnights will assist with assuring appropriate payment for subsequent post-acute care and will not compromise services for the beneficiary. We appreciate CMS's consideration for this proposed change.

We believe there is a clinical basis to totally remove the three-day hospital stay as a requirement for skilled nursing care eligibility. The SNF environment and the types of patients treated are totally different in 2005 from 1965 when this requirement was implemented. There have been phenomenal changes in the health care delivery system over the last 40 years since the Medicare legislation was enacted and Congress imposed this requirement. In section III.M. of the July 1999, final rule, CMS discusses "presumption of coverage" when a beneficiary scores in the top 26 RUG-III categories and they are deemed to qualify for skilled care. Often, residents are admitted to SNFs that meet these requirements without ever having been admitted to an acute care hospital. We encourage CMS to consider the impact on the Medicare program of reducing or eliminating the three-day qualifying stay. Such a change could save the Medicare program

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Centers for Medicare & Medicaid Services  
Date  
Page 8

significant dollars for eliminated hospital stays and allow beneficiaries placement in a less intensive setting.

**Summary**

Generally, the SNF PPS program has allowed Medicare Part A patients to continue to receive quality care, while reducing costs and risk to the Medicare Trust Fund. We believe strongly that the proposed changes in the look-back period, use of grace days, and projecting therapy minutes would be very damaging to the SNF's ability to provide the quality post-acute care for Medicare Part A patients desired by all. Beneficiaries have earned the right to utilize the Medicare program through their payment of payroll taxes throughout their work lives. The proposed RAI Manual changes could be damaging to many Medicare Part A patients (especially those living in rural communities) by potentially limiting access to coverage and services. The proposed changes could result in increased costs through increased re-hospitalizations and less rehabilitated SNF population ultimately requiring more, not less, services.

We respectfully submit our comments and appreciate your consideration when deciding on the proposed changes. Should you have any questions or if we can be of further assistance, please feel free to contact [insert name and phone number].

Sincerely,

*Kristy Tanner*  
Administrator

**Transmitted via e-mail to: <http://www.cms.hhs.gov/regulations/ecomments>**

Submitter :

Tammy Stephenson

Date: 07/11/2005

Organization :

Schmidt Wallace Healthcare

Category :

Long-term Care

Issue Areas/Comments

Management Company, Inc.

GENERAL

GENERAL

See Attachment

CMS-1282-P-65-Attach-1.DOC

Form letter

same as # 64

**Submitter :** Mr. Tom Hathaway  
**Organization :** Redmond Health Care Center  
**Category :** Long-term Care

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I have read the AHCA response to proposed changes in the PPS reimbursement changes being considered. While I understand the need for budgetary control and reduction of the deficit, I do not agree with reductions in SNF reimbursements.

I am the Administrator for a rural nursing home in Redmond, Oregon. We are the only SNF provider in this city and there are two hospitals referring patients to us. Our rehabilitation unit is staffed with Physical and Occupational Therapists, we have licensed nurses on the floor 24-hours a day. We have CNA's on the floor 24-hours a day. While we are licensed for 74 beds, our average daily census is 32 patients. It is our short-term rehab SNF patients that keep us from going broke. Any reduction in reimbursement could cause us to go under.

I have ten years of experience in managing SNF's. I've watched Medicaid and Medicare reduce and raise their rates several times in multiple venues. There are always a few consistent factors that are never considered: CMS demands and expects perfection in the imperfect world of health care whether there are funds to pay for the staff to provide care or not, CMS imposes it's rules without consideration to the fact that SOMEBODY has to pay the staff to do the work.

Reducing reimbursement or complicating the delivery of care processes will only result in lower quality of services and a negative impact on the comfort and health of the frail, elderly and sick.

Having CMS impose higher standards with more strict enforcement while reducing reimbursement is wrong. Not all facilities have deep pockets and hundreds of patients. Some of us are barely surviving as it is. Big government can easily say "send the patient someplace else," but doesn't the patient or the family have a right to have their loved one within driving distance?

**Submitter :** Ms. PATRICIA ANDERSEN  
**Organization :** OKLAHOMA HOSPITAL ASSOCIATION  
**Category :** Health Care Provider/Association

**Date:** 07/11/2005

**Issue Areas/Comments**

GENERAL

GENERAL

SEE ATTACHMENT

CMS-1282-P-67-Attach-1.DOC



July 11, 2005

Mr. Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1282-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

**Ref: CMS-1282-P; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006; (70 Federal Register 96, May 19, 2005)**

Dear Dr. McClellan:

The Oklahoma Hospital Association (OHA), on behalf of our more than 130 hospital members--many of which are the only providers of skilled nursing care, home health care, hospice care, rehabilitative care, and psychiatric care in their communities and may also operate an intermediate care or residential care nursing home or another type of senior living service their community--appreciates the opportunity to comment on the proposed rule related to the Skilled Nursing Facility Prospective Payment System (SNF PPS) for FFY 2006.

**Case-Mix Adjustment and Other Clinical Issues**

As part of the reasoning used to reevaluate the need to remove the temporary payment add-ons and replace it with case-mix refinements, the Centers for Medicare & Medicaid Services (CMS) indicated that "SNF PPS rates have generally covered the cost of care to Medicare beneficiaries" to the extent that the estimated 2005 Medicare margin for freestanding SNFs was 13 percent. This was included in the March 2005 MedPAC report in which 2003 cost report data was used to project this

margin. Alarming, the same report indicated that the 2003 Medicare margin for Hospital-based SNFs was a -87 percent. The report indicated that this might be because *“hospitals have higher cost structures than freestanding nursing homes”*.

**In Oklahoma, the average Medicare margin “earned” by hospital-based skilled nursing facilities has declined from a margin of negative 14% in 1997 to a margin exceeding negative 130% in 2003! In that period, the number of hospital-based SNFs has dropped from 40 to 20. At the current rates, hospitals cannot even cover the direct costs of caring for patients admitted to their skilled nursing units. In Oklahoma, hospitals care for the most critically ill skilled nursing patients and have a relatively short length of stay into which concentrated medical and rehabilitative care is provided so that the patient can return to a much lower level of care returning them to their homes or residential care facilities.**

While OHA supports CMS effort to begin to implement fundamental changes in the SNF PPS case-mix system, **OHA believes that replacing the add-ons with case-mix refinements that decrease overall Medicare payments by 3% only increases the financial hardship currently experienced by SNFs, especially hospital-based SNFs, as evidenced by their 2003 Medicare margin.**

The proposed case-mix refinements can be separated into two components. First, there is the addition of nine Resource Utilization Group (RUGs) categories to better account for the medical complexity of certain patients in the Rehabilitation categories who also have conditions that would otherwise place them in the Extensive Services category. OHA applauds CMS effort to address the inequity in payment regarding this segment of skilled nursing facilities patients. OHA supports the proposed increase to 53 RUGs groups and the subsequent case mix index re-weighting.

Second, there is an 8.4% add-on to the nursing component of the case-mix weights for all 53 RUGs categories. This results in a 3% increase in overall payment and is intended to better account for the non-therapy ancillary costs.

Although we support CMS’ effort to rectify a long-standing deficiency in the SNF PPS case-mix system-- *“the ability of the SNF PPS to account adequately for non-therapy ancillary services”*-- we disagree with the methodology and subsequent amount of the add-on. The process used to derive the add-on was based on an analysis of the Inpatient Rehabilitation Facility (IRF) PPS outlier policy. In that system, the outlier was set at 3 percent of the aggregate payments. This outlier was chosen as the guiding benchmark to address the adequacy of payment for SNF non-therapy ancillary costs. However, there is no natural correlation between the IRF outlier costs and SNF non-therapy ancillary costs. Therefore, **OHA believes that this arbitrarily derived add-on that results in a 3 percent reduction in Medicare payment when netted against the removal of the temporary add-ons is inadequate.**

**Proposed Refinements to the Case-Mix Classification System*****AIDS Add-On***

**OHA concurs with CMS that the expiration of the BBRA mandated temporary add-ons does not necessarily affect the temporary AIDS add on of 128 percent. Therefore, we agree with CMS's decision to retain the add-on for FY 2006.**

***Revision to the Fourteen (14) Day "Look-back" Provision***

CMS analyzed the Minimum Data Set (MDS) focusing on four items in the Special Services section that classify patients into the Extensive Care RUGs category and that have a 14-day look-back period: intravenous (IV) medications, suctioning, tracheostomy care, and the use of a ventilator or respirator. CMS noted in its analysis that many patients are classified into Extensive Services solely because of the receipt of such services in the acute setting prior to SNF admission and within the look-back period. CMS is seeking comment on the revision of MDS Manual instructions to include only those special care services furnished after a SNF admission or re-admission.

OHA believes that a "look-back" provision of some length must be maintained in the SNF PPS process due to the residual impact of acute care services on the patient and costs of care in skilled nursing facilities for the first few days post admission.

Skilled nursing facility patients must be admitted after an acute care stay in a hospital and most patients admitted to hospital-based skilled nursing facilities are admitted with significant medically complex needs and in fragile clinical conditions. The first post-admission days in skilled nursing facility are an intense period of adjustment for both staff and patient. The services provided by the skilled nursing facility staff are intensive and are critical to determining an appropriate initial plan of care for the patient moving forward for the next few days. The "look-back" provision allows providers to recoup payment for these increased costs of care related to the assessment, planning, and delivery of services that are critical to the care and safety of the patient during their first few days of transitioning between settings.

**If CMS believes that a comprehensive study is warranted that would be used to determine an appropriate revision to the "look-back" provision while still allowing providers to be appropriately reimbursed for the necessary increased costs of care during this critical transition between care settings, OHA supports that. However, until such time a study is done, OHA does not support any proposed change to the current look-back provision**

***Elimination of Grace Days for Five-Day Prospective Payment System (PPS) Minimum Data Set (MDS)***

### *Assessment*

The five-day grace period was a process option to be exercised by a provider in determining when to set the assessment reference date (ARD) of the first PPS MDS assessment. The goal was to allow providers flexibility in setting the look-back period for conducting this first assessment to determine payment for the first days of a long-term care stay.

It is OHA position that these grace days should not be eliminated, and thereby remaining an option for providers, especially for the first post-admission PPS assessment. The reasons for this are essentially the same as those expressed for continuing the "look-back" provision. The first few days of a patient's stay post-admission from the acute care setting are an intense period of information gathering, assessment, care planning and monitoring of the patient, based on residual effects of the post acute care treatment plan and the effects of transitioning between settings. **Providers should continue to have the option and flexibility of using grace days to set an ARD sometime within the first 5 days of admission based on the variables outlined above.**

### **SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists**

Many skilled nursing facilities, primarily ones in distressed urban and remote rural areas struggle to provide medical services due to a severe shortage of physicians. The use of physician extenders such as nurse practitioners (NPs) and clinical nurse specialists (CNSs) has become critical to maintaining adequate and competent healthcare coverage in facilities. In addition, it has been scientifically proven that facilities with NPs and CNSs participating in the care of long term care patients, improves quality of care and patient outcomes, and are essential educational resources for the interdisciplinary care team. OHA strongly disagrees with CMS' proposed prohibition of NPs and CNSs to certify/recertify SNF care based on a presumed conflict of interest for those professionals with an "indirect employment relationship" with the facility.

We believe CMS' interpretation of 424.20(e)(2) to be inconsistent with that of 424.20(e)(1) as it applies to physicians in the same function. 424.20(e)(1) reads, "(e) Signature. Certification and recertification statements may be signed by-- (1) The physician responsible for the case or, with his or her authorization, by a physician on the SNF staff or a physician who is available in case of an emergency and has knowledge of the case." "Physician on staff" is a phrase that describes one of two relationships between an SNF and a physician. "On staff" describes either a direct employment relationship between the physician and the SNF whereby the physician is paid by the SNF for services, or an indirect relationship whereby the physician has been granted privileges to admit and care for patients. If physicians in each of these relationships are permitted by CMS to conduct certification/recertifications without CMS presuming a conflict of interest is being presented, why are NPs and CNSs expected to have a conflict of interest under these very similar conditions? We

find CMS' opposing positions on 424.20(e)(1) and 424.20(e)(2) to reflect a double standard.

**OHA urges CMS to reconsider its interpretation of 424.20(e)(2) and an "indirect employment relationship" and reverse its proposed restrictions on NPs and CNSs for certifying Medicare services based on that interpretation.**

### **Proposed Revisions to the SNF PPS Labor Market Areas**

In FFY 2005, CMS implemented revised wage areas based on Core-Based Statistical Areas (CBSAs). This change had a significant redistributive impact with many areas experiencing substantial increases or decreases in their wage adjustment. As a result, CMS provided a blended wage index in FFY 2005 for hospitals that were harmed by the redefinition of wage index areas. Hospitals that would have received a higher wage index under the prior geographic area definitions were provided a blended wage index combining 50% of the wage index based on the new definitions and 50% based on the old definitions. CMS proposes to end this protection and determine 100% of the wage index based upon the new CBSA configurations beginning in FFY 2006.

According to CMS, "*Given the significant payment impacts upon some hospitals because of these changes, we provided a transition period to the new labor market areas in the FY 2005 IPPS final rule*". The redefinition of wage areas will have similar impacts on SNFs. We urge CMS to provide the same transition as was applied to the inpatient PPS.

The new area designations also result in some facilities that were previously classified as urban being reassigned to rural areas. **As part of the transition for the inpatient PPS, CMS allowed urban hospitals that became rural under the new definitions to maintain their assignment to the wage index of the urban area to which they previously belonged for a three year period. This same protection should be extended to SNFs.**

### **Qualifying Three-Day Inpatient Hospital Stay Requirement**

OHA appreciates CMS giving consideration to "observation status" in an acute hospital as becoming a factor in calculating Medicare's three-day qualifying hospital stay. As CMS notes in the proposed rule, the acute care LOS has decreased since implementation of the SNF PPS and new acute care services have been developed. OHA believes "observation status" should be made part of the three-day qualifying hospital stay for determining the SNF benefit.

As CMS has stated in the proposed rule, "observation status" is a new acute care service concept not envisioned when SNF PPS was implemented. It has been developed and is used in nearly all hospitals to address the challenges of overcrowding of emergency departments and is an integral part of a patient's overall acute care experience. This coupled with increased efficiencies in

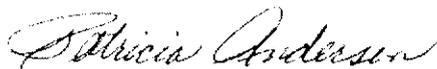
diagnosis and treatment of acute care conditions, has decreased inpatient hospital stays dramatically. Incorporating a pre-admission "observation status" into the inpatient stay qualifier would permit beneficiaries to transition skilled nursing facilities more appropriately.

**OHA urges CMS to adopt "observation status" as part of the qualifying hospital stay requirement for determining eligibility for the SNF benefit.**

OHA appreciates the opportunity to comment on the proposed rule. If you have any financial related questions regarding our comments, please contact Patricia Andersen, CPA, VP-Finance & Information Services at the Oklahoma Hospital Association at 405-427-9537 or by email at [pandersen@okoha.com](mailto:pandersen@okoha.com).

Sincerely,

OKLAHOMA HOSPITAL ASSOCIATION



Patricia D. Andersen, CPA  
VP-Finance & Information Services  
Oklahoma Hospital Association  
4000 N Lincoln Blvd  
Oklahoma City, OK 73105

**Submitter :** Ms. JANET CUPPLES  
**Organization :** P&M HEALTHCARE  
**Category :** Health Care Provider/Association

**Date:** 07/11/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-1282-P-68-Attach-1.DOC

This commentary is in reference to File Code CMS-1282-P Issue IV.  
Consolidated Billing.

I would like to register the following concerns with respect to the consolidated billing provisions for Skilled Nursing Facilities:

1. High Cost Items

There are a number of codes included in SNF Consolidated Billing which are both extremely high cost and for services which are not routinely provided in the SNF setting. I believe that these codes should not be the responsibility of the SNF. These include but are not limited to:

- 78815 – PET Scan
- L5400 to L5500 – Prosthetic Codes
- 11040 to 11044 – Debridement Codes
- 99201 to 99205 and 99212 to 99215 when billed by entity other than physician

2. Category I Exclusions

Charging these items to the SNF when the procedures/services are not performed in a hospital or CAH represents an undue financial hardship for the SNF as the cost of these services generally exceeds the SNF's reimbursement under PPS. The physicians ordering these services are often insistent upon the services being provided at free-standing clinics where they have privileges or other caseload. Also, in some communities, the free-standing clinics are the only locations which provide the services ordered by the physician. Therefore, I feel that Category I exclusions should be listed as Consolidated Billing exclusions without regard to the site of service.

3. Business Office Management Issues

- I believe that the amount of research necessary to determine which codes are included or excluded in Consolidated Billing is beyond the expertise of most SNF business office personnel.
  - The SNF Help File, which is an extremely user-friendly tool, has too many errors to be useful.
  - The Annual and Quarterly updates are too difficult to use because not all codes are listed.
  - The SNF Provider Supplier Coding File (File 1) is somewhat useful, but apparently not definitive with regard to codes that are used by providers other than physicians (99201-99215).

- If the determination of inclusion versus exclusion is based upon HCPCS coding, then there should be a single source document available for everyone's use. If inclusion is determined by site or service or type of bill, then that should be clearly noted. I have experienced numerous instances where I have sought a response from our Intermediary and been given information which is in conflict with the information given to the outside provider by the same Intermediary.
- It is also too cumbersome for the average business office manager to determine how much to pay, when the agreement with the outside provider is to pay at the Medicare Allowable rates. Many codes such as L codes, J Codes, 11000 codes are not listed in the Fee Schedule Look Up. Often, the outside provider does not have a Fee Schedule amount to quote, so the task of researching payment amounts for a wide variety of services and procedures becomes a time-consuming and difficult task.

#### 4. Reasonable Payment

My last comment is that I feel that outside providers should be given a clear directive that it is not acceptable to charge the SNF in excess of the Medicare Allowable. While the vast majority of outside providers that we deal with have adhered to this, there are a few providers which will not agree to reasonable pricing. While they may offer a 40% discount from their list price, it still amounts to pricing which is two to three hundred times the Medicare Allowable. In one note-worthy case, the SNF was charged \$12,000 for a single out-patient visit.

**Submitter :** Ellen R. Strunk PT, MS, GCS  
**Organization :** Restore Management Company, LLC  
**Category :** Health Care Provider/Association

**Date:** 07/12/2005

**Issue Areas/Comments**

**GENERAL**

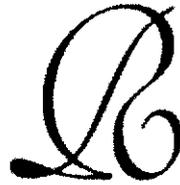
GENERAL

Please see attached

CMS-1282-P-69-Attach-1.DOC

*Restore Management Company, LLC is a community of professionals committed to excellence in service.*

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July 12, 2005

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
**Attention: CMS-1282-P**  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006 – Proposed Rule (Volume 70, Number 96; pp 29069-29162; 42 CFR Part 424)**

Dear Medicare & Medicaid Services:

Restore Management Company, LLC submits the following comments in response to the Proposed Rule for Skilled Nursing Facilities for FY 2006.

Restore Management Company, LLC is a provider of rehabilitation services (speech-language pathology, physical, and occupational therapy) for the skilled nursing, home health, and outpatient settings.

We wish to comment on the four following areas in the 2006 Proposed Rule: (1) Case-Mix Adjustment and Other Clinical Issues; (2) Proposed Refinements to the Case-Mix Classification System; (3) Concurrent Therapy. These comments are described in detail on the following pages.

## I. Case-Mix Adjustment and Other Clinical Issues

### **Development of the Case Mix Indexes**

On Page 29077, the Proposed Rule states – *“The therapy weights for the nine proposed Rehabilitation Therapy plus Extensive Services groups were identical to those for the comparable existing RUG-III rehabilitation therapy groups. Although we are capturing increased medical/clinical complexity with the proposed new groups, the therapy contribution remains the same as for the existing therapy groups.”* The Proposed Rule goes on to say, *“The effect of the increased number of groups and changes in the case mix indexes should be distributional. By this we mean that the relative weights assigned to each RUG-III group would shift so that the proposed new Rehabilitation plus Extensive groups would have the highest relative weights and the weights for other RUG-III groups would decrease proportionally.”*

**Comment:** We appreciate CMS's efforts to improving the specificity with which the RUG-III categories capture beneficiary characteristics. However, **as rehabilitation providers and advocates for our resident's rehabilitation needs, we do take issue with the outcome of the therapy weights.** As a result of the new RUG-53 system, the therapy indexes (and therefore the therapy components of the total rates) actually decreased for the highest rehabilitation RUG-III categories (Rehab Ultra High and Rehab Very High). Therefore **providers will be paid at a higher daily rate when they provide rehabilitation services at a lower intensity.** We are concerned that this provides an incentive to provider fewer rehabilitation services, and does not adequately pay for the therapy resources needed by those providers who do provide residents with a higher intensity of therapy. There are checks and balances in place to prevent SNF providers from unnecessarily placing patients in the higher categories, such as focused medical reviews and post-payment reviews. In addition, there are several fiscal intermediaries who are currently drafting SNF RUG-III Local Coverage Determinations.

## II. Proposed Refinements to the Case-Mix Classification System

### **(a) Development of the Case Mix Indexes**

Page 29079 of the Proposed Rule states: *“We note that in creating the SNF PPS, the Congress enacted the only PPS legislation in the Medicare program that does not establish an outlier policy to capture high variability in resource utilization. Therefore...we believe that it is appropriate to adjust the case-mix weights for all 53 groups...to better account for non-therapy ancillary variability. We would do this by exercising our authority under section 1888(e)(4)(G)(i) of the Act to establish an “appropriate adjustment to account for case mix,” in order to maintain access and quality of care for heavy-care patients.”* The proposed rule continues with *“Based on this analysis, we are proposing an increase to the nursing component of the case-mix weights (the component that includes non-therapy ancillaries) of approximately 8.4 percent.”* And later on page 29079 the proposed rule goes on to say, *“...these additional payments would partially offset the expiration of the temporary add-on payments that will occur, under the terms of section 101(c) of the BBRA, upon the implementation of this proposed case-mix refinement. We believe that implementing the proposed case-mix refinement in this manner will carry out Congressional intent...while at the same time ensuing that payments under the SNF PPS continue to support the quality of care furnished in this setting.”*

**Comment:** CMS has proposed a case-mix refinement as outlined in the BBRA. However, the new proposed structure is specific only to the nursing component and the non-therapy ancillary component. It does not address the therapy component at all, and therefore should not be considered a 'true' case-mix refinement. As stated above and in the proposed rule, Congress' intent was to support the quality of care furnished in the SNF setting. Rehabilitation is a vital component to that overall quality of care. There have been several studies published in recent years to support the rehabilitation outcomes achieved in the SNF setting:

1. "Outcomes of Rehabilitation Services for Nursing Home Residents", *Archives of Physical Medicine & Rehabilitation*, August 2003.
2. "The Relation between Therapy Intensity & Outcomes of Rehabilitation in Skilled Nursing Facilities", *Archives of Physical Medicine & Rehabilitation*, March 2005.
3. "Skilled Nursing Facility Rehabilitation and Discharge to Home after Stroke", *Archives of Physical Medicine & Rehabilitation*, March 2005.
4. "Rehabilitation in Skilled Nursing Facilities: Effect of Nursing Staff Level and Therapy Intensity on Outcomes", *American Journal of Physical Medicine & Rehabilitation*, September 2004.

**Removing the therapy add-ons to the RUG-III classification without adequately addressing the therapy component presents an unnecessary burden to providers.** In the ensuing years since the therapy add-ons were created, the cost of providing therapy has only increased. The new system does not acknowledge the real world burdens providers have to face with recruiting, staffing, and competency of therapists. **SNF providers are expected to provide (and should provide) high quality therapy services to its residents. Recent studies support that they are. In return, they should be adequately compensated.**

**(b) Removal of the Look-Back Period**

*Pg. 29079-29080 of the Proposed Rule states: "Further, the creation of the proposed new Rehabilitation plus Extensive Services groups underscores the importance of ensuring the accuracy of patient classifications, particularly with regard to those categories, such as Extensive Services, that encompass medically complex patients. One way to accomplish this could be by ensuring that the MDS data used in making such classifications reflect only those services that are actually furnished during the SNF stay itself rather than during the preadmission period (for example, during the prior qualifying hospital stay)." And later " Therefore we seek comment on the potential savings and other impacts of revisiting the MDS manual instructions to include only those special care treatments and programs furnished to the resident since admission or re-admission to the SNF."*

**Comment** – Patients who receive services such as IV feedings, IV medications, ventilation, tracheostomy care, etc in the hospital are by definition more medically complex patients. Because of the services they received in the hospital and their overall medical condition they become more susceptible to developing secondary conditions such as Pneumonia, sepsis and/or bacterial infections.

Patients are often admitted to the SNF immediately after receiving these services. In some cases, the same day treatments/services are rendered. The negative side effects/reactions to these services will more likely occur in the SNF setting. Lab work, medical treatment including medications and follow up x-rays will have to be provided in the SNF setting. Along with more intensive nursing services the patient will also require more intensive therapy services. These patients will more likely be extremely deconditioned and will have already lost muscle mass and strength. They will need therapy to learn compensatory strategies to perform the simplest of activities such as bed mobility, swallowing and simple ADL's. As the patient increases in strength therapy services will progress to higher level task such as transfers/ambulation, self feeding, independent ADL's etc.

**Removing the hospital "look back" period would negatively impact the SNF resulting in the following:**

- **Increase cost to the SNF without means of reimbursement**
- **Increase in re-hospitalization**
- **Decrease in quality and continuity of care for the more medically complex patients**

**(c) Qualifying 3 day Inpatient Hospital Stay Requirement**

*Page 29099 of the Proposed Rule states: "More recently, it has been suggested that because of changes in hospital admission practices that have occurred since congress enacted this provision in 1965, some patients who at that time would have been a hospital inpatient for at least 3 days are instead now placed in observation status initially, before being formally admitted as a hospital inpatient. Observation status is a distinct service that is discussed in the IOM in Pub 100-02, Chapter 6, in which a patient who needs more care than can be provide in a emergency room is moved form the emergency room, placed in a hospital bed in the appropriate hospital unit, and monitored by the unit nursing staff. The longstanding policy interpretation of the SNF benefits prior hospital requirement does not count hospital observation time that immediately precedes an inpatient admission toward meeting the requirement."*

**Comment** - Currently hospitals are placing patients in observation more often to determine if a level of care is going to continue and warrants a full admission. The level of care often times does continue and the patient is officially admitted to the hospital. In these cases the services between the observation day and the hospital stay are the same in skill level and complexity.

On page 29099 of this proposed rule it states *"In order to target the SNF benefit more effectively at the limited segment of the nursing home population...(that is, those beneficiaries requiring a short-term, fairly intensive stay in a SNF as a continuation of an acute hospital stay of several days), the Congress established as a prerequisite for SNF coverage a requirement that a beneficiary must first be a hospital inpatient for "not less than 3 consecutive days before his discharge from the hospital"...* **If the true intent of the rule was to target patients receiving inpatient type care for at least 3 days prior to SNF admission then the observation period should be counted toward the 3 day hospital stay.**

**(d) Elimination of Grace Days**

**Page 29080** of the Proposed Rule states: *"...we have received recommendations to decrease or eliminate the grace day period specifically for the 5-day PPS MDS assessment. We invite comments on this specific recommendation as well as decreasing or eliminating the grace periods associated with all PPS MDS assessments"*

**Comment** - The Resident Assessment Instrument (RAI) Manual (revised December 2002 and updated August 2003) states *"...there may be situations when an assessment might be delayed and CMS has allowed for these situations by defining a number of grace days for each Medicare assessment...Grace days can be added to the Assessment Reference Date in situations such as an absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. **Grace days may also be used to more fully capture therapy minutes or other treatments.** (bold added) The use of grace days allows clinical flexibility in setting ARDs, and should be used sparingly."*

In the Final Rule of July 30, 1999 (Federal Register 42, parts 409, 411, 413, 489), CMS commented on their decision to allow grace days at the 5 day assessment. Since that time, there has been no significant improvement in the acuity of patients admitted to the SNF; if anything, they are more acute and therefore the grace days are warranted. (p. 41657) *"...The grace days are also provided to offset any incentive that facilities may have to initiate therapy services before the beneficiary is able to tolerate that level of activity... we do expect that many beneficiaries who classify into the rehabilitation category will have 5-day assessment reference dates that fall on grace days...There are many cases in which the beneficiary is not physically able to begin therapy services until he or she has been in the facility for a few days. Thus, for a beneficiary who does not begin receiving rehabilitation therapy until the fifth, sixth, or seventh day of his or her SNF stay, the assessment reference date may be set for one of the grace days in order to capture an adequate number of days and minutes in section P of the current version of the MDS to qualify the resident for classification into one of the rehabilitation therapy RUG-III groups...Another reason for the provision of three grace days for the 5-day assessment was to make it possible for beneficiaries to classify into the two highest RUG-III rehabilitation subcategories. Classification into the Ultra High and Very High Rehabilitation subcategories is not possible unless the beneficiary receives the subcategory's minimum level of services during the first seven days of the stay. We also intended to minimize the incentive to facilities to provide too high a level of rehabilitation therapy to newly admitted beneficiaries. Having these extra few days allows time for those beneficiaries who need it, to stabilize from the acute care setting and be prepared for the beginning of rehabilitation in the SNF. We expect facilities will not compromise any beneficiary's health by beginning rehabilitation therapy prematurely or at a level that is too rigorous for the individual's status...In summary, use of grace days is acceptable and permitted for patients with any condition."*

As stated earlier, there has been no evidence presented that would reverse the explanation made by CMS in 1999. Hospital stays are getting shorter and the acuity of the patient admitted to the SNF is increasing. Therefore there are many cases in which the beneficiary is not physically able to begin therapy right away. There are also cases where the beneficiary will benefit from the ultra high rehabilitation and very high rehabilitation RUG-III categories, but would be unable to physically achieve that level of care without the grace days. In addition, only one discipline may be ordered

on the first day, but after the physician has time to see the beneficiary in the SNF setting, more disciplines may be added during the first few days of admission. Not allowing grace days may increase the incentive to wait until day 10 to add additional appropriate therapies. Skilled Nursing Facility's are increasingly being measured on the quality of care they provide as well as their ability to provide the level of service expected and deserved by Medicare beneficiaries. **The grace days allow the SNF's to individualize the intensity of care provided to its residents, while avoiding unnecessary risk.**

**(e) Elimination of Projection of Anticipated Therapy Services during the 5 day PPS Assessment**

**Page 29080 of the Proposed Rule states:** *"Another example of a possible policy change on which we invite comment would be whether it might be appropriate to eliminate the projection of anticipated therapy services during the 5-day PPS assessment."*

**Comment** – The allowance for projected minutes of anticipated therapy during the 5 day assessment insures the intensity of services provided to the beneficiary is appropriate to his/her needs. For many of the same reasons listed above, there may be instances where a patient is physically unable to tolerate a high intensity of therapy service(s). The projection only allows a provider to project to the Low Rehabilitation, Medium Rehabilitation, or High Rehabilitation categories which decreases the risk of abuse for this provision. The provision allows the resident's physician adequate time to determine if the patient is a candidate for rehabilitation services, rather than feeling pressured to write the orders on the day of admission in order to get therapy started on the first day. The 5 day MDS pays for services provided only during day 1 through 14. If this provision were eliminated, it would present a hardship to SNF's since payment would not adequately cover for the services rendered on day 6 to 14 in those cases where a beneficiary is too ill to participate in therapy for the first couple of days or has to have short, infrequent periods of therapy during the first few days of SNF admission. It also allows the care plan team to more adequately assess the resident's needs and seek orders for additional therapies when indicated.

CMS is promoting the public's access to information on provider's ability to influence health outcomes through its "compare websites". In order to comply and succeed, **providers must have the resources they need to provide the services needed by its residents. Providing the Projection of Anticipated Therapy Services allows providers to do just that. Taking it away may significantly impact the quality of care beneficiaries receive.**

### III. Concurrent Therapy

According to CMS, the practice involves a single professional therapist treating more than one Medicare beneficiary at a time. In contrast to group therapy, in which all participants are working on some common skill development, each beneficiary who receives concurrent therapy is not receiving services that relate to those needed by any of the other participants. CMS' concern is that although the care that each beneficiary receives may be individually prescribed, it may not conform to Medicare coverage guidelines; that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare. CMS is considering once again whether there is a need to issue additional guidelines to preclude the inappropriate provision of concurrent therapy and invites comment on the most effective way to prevent the abuse of this practice, and to ensure that concurrent therapy is performed only in those instances where it is clinically justified. CMS invites comments on the most effective way to ensure that concurrent therapy is performed only in those instances where it is clinically justified.

**Comments:** There are three issues that should be included in this discussion:

- I. Skilled services provided through the provision of concurrent therapy
- II. Issue of abuse and professional responsibility
- III. Most effective way to prevent the abuse of this practice.

**I. Skilled services provided through the provision of concurrent therapy.**

According to the CMS definition provided in the SNF PPS proposed rule for FY 2002 (66 FR 23991, May 10, 2001, concurrent therapy *"involves a single professional therapist treating more than one Medicare beneficiary at a time – in some cases, many more than one individual at a time. In contrast to group therapy, in which all participants are working on some common skill development, each beneficiary who receives concurrent therapy likely is not receiving services that relate to those needed by any of the other participants."*

**On page 29077** of the 2006 Proposed rule it reads: *"...reclassified the patients into the proposed 53 groups with their associated wage-weighted minutes of resident-specific and nonresident-specific staff time" (underline added)... "multiplied the population in each group by wage-weighted minutes for each of the staff types... derived an average for the group... (nursing and therapy staff minutes were calculated separately)".* This underscores the fact that the SNF Prospective Payment System was developed on different payment principles than any other payment system within Medicare. This foundation of payment is the context for interpreting the skilled services. One can not apply the same payment interpretations from outpatient Part B therapy to SNF PPS. The outpatient Part B benefit is paid from the RBRVS where the work and practice value are predetermined in each code. The RBRVS is based upon individual's time and work and practice. Alternatively, the Part A benefit is paid from the SNF PPS which is based on the 'minutes' of service provided to the patient during any particular week. Concurrent therapy is minutes of skilled service provided to the patient. Therefore the different payment structures call for different 'calculators' into which you put skilled services to determine payment.

The 2006 proposed rule goes on to say on page 29082 that *“Although the care that each beneficiary receives may be prescribed in his or her individual plan of treatment, it may not conform to Medicare coverage guidelines; that is, the therapy is not being provided individually, and it is unlikely that the services being delivered are at the complex skill level required for coverage by Medicare.”* CMS has not provided any additional information in this proposed rule that would contradict their conclusion reached by the SNF final rule in 2002 – namely that **“concurrent therapy can have a legitimate place in the spectrum of care options”**.

There are many clinical scenarios where concurrent therapy represents the complexity and sophistication of services expected by Medicare. This level of care must be reflected in the documentation provided, as with any Medicare covered service. In addition, the level of care provided is of significant benefit to the patient(s).

- II. Issue of abuse and professional responsibility.** CMS states on page 29082-29083, that *“...facility management might inappropriately attempt to increase productivity by coercing a therapist, against his or her own professional judgment, to perform concurrent therapy...we have continued to encounter reports of facilities that attempt to override the therapist’s professional judgment and have concurrent therapy performed in the absence of valid clinical considerations...”*

Concurrent treatment (or dovetailing) has been a service delivery option for many years by other health care providers (such as physicians) and the SNF setting should not be singled out for regulation. Any coverage guideline regarding this type of treatment should be fairly applied across all settings.

It would be a mistake for CMS to issue rules that govern the professional responsibility of the therapist. State practice acts and the professional associations have set out Standards of Practice and Codes of Ethics for the professional therapist to follow. The decision to choose concurrent treatment as a service delivery option is, and should continue to be, made by the therapist based on his/her clinical judgment because only the therapist can know the clinical indicators that would make individual, concurrent, or group treatment the best option for treatment (or the appropriate combination thereof). The choice of treatment delivery options should be left to the therapist’s judgment based on clinical factors rather than being dictated by regulation. If the therapist is having issues and feeling pressured, it is his/her responsibility to address those concerns with his/her employer. There will always be practice issues and concerns that arise in the real world which professionals will have to address. It is not the role of CMS, nor do therapists desire for CMS to intercede on our behalf.

We see no reason to modify the current CMS position: *“we continue to believe, as do many of the commenters, that concurrent therapy has a legitimate place in the spectrum of care options available to therapists treating Medicare beneficiaries. Our goals are to safeguard the health and safety of beneficiaries and assure that they are provided the most effective, skilled care available. We agree that, at times, such care can be provided concurrently with another patient, as long as the decision to do so is*

*driven by valid clinical considerations.*" (Federal Register, Vol. 66, No. 147, at p. 39568)

- ///. Most effective way to prevent the abuse of this practice.** Clarification of an issue like this is always beneficial as it is inappropriate for a provider to force a professional therapist to perform an activity that is inappropriate based upon the professional therapist's clinical judgment, and what is truly in the best interests of the patient. However, current integrity oversight within the Medicare system can directly address the reported instances of abuse by "facility management". These methods include:
- a. Documentation requirements in the SNF currently require therapists to document the level of complexity and sophistication of services for reimbursement.
  - b. Focused medical reviews of Part A stays by FI's currently review the medical necessity the therapy services, whether they are provided at the level billed, and the clinical justification of said services.

In lieu of an attempt to stop rehabilitation professionals from providing clinically sound treatment that is in the beneficiary's best interest and using professionally accepted procedures confirmed instances of abuse should be handled directly with the Medicare approved facility. The integrity of the clinical discretion of the therapist in determining what is in the beneficiary's best interests must be preserved without rule of thumb determinations and unconfirmed reports of abuse.

**Submitter :** Mr. Tod Dunfield  
**Organization :** Regency Care Center at Monroe  
**Category :** Long-term Care

**Date:** 07/12/2005

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Please See Attachment

I am very concerned regarding many of the proposed reimbursement changes. The letter I have attached more fully addresses these issues, however I would like to further comment on two areas. First the proposed elimination of the 14 day look back period will have a very negative impact on the ability to provide adequate care to our residents. Without the 14 day look back it will be difficult to acquire an accurate picture of the needs of the residents and the costs associated with providing them adequate care.

Second, I am concerned about the proposed elimination of the use of grace days. Elimination of the ability to use grace days will have a negative impact on the levels of care a resident will be able to access. I believe that grace days, accurately used, play an important role in providing quality care at the levels required by our residents and then allows appropriate reimbursement. I agree that these grace days should be used carefully and on a limited basis, however eliminating them entirely would penalize those that need higher levels of care and increased therapy minutes to more fully recover.

I appreciate the opportunity to comment and I urge the proposed changes be reviewed in light of the concerns my comments and this letter have raised.

Sincerely,  
Tod Dunfield

CMS-1282-P-70-Attach-1.DOC

CMS-1282-P

**Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006**

Submitter: Tod Dunfield, Administrator – Regency Care Center at Monroe

Facility/Organization: Regency Pacific, Inc.; Hilltop Health Care, Inc.

Date: July 11, 2005

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Thank you for the opportunity to submit comments on this proposed rule. As requested, the following comments are organized by referencing the identifier that precedes the section, as well as the page number.

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**Case-Mix Adjustment and Other Clinical Issues – 29075-29078**

**Topic: (p. 29075)**

This legislation specified that the payment adjustments would continue until the later of: (1) October 1, 2000, or (2) implementation of a refined case-mix classification system under section 1888(e)(4)(G)(i) of the Act that would better account for medically complex patients.

**Comments:**

We disagree that the implementation of this refined case-mix classification system would better account for medically complex patients, and feel that the proposed refinement is somewhat premature. We have great concern that the proposed rule will have a negative impact on our nursing homes in regards to financial stability and quality of resident care. We ask that you carefully consider our comments.

**Topic: (p. 29076)**

Moreover, ongoing analysis of the SNF PPS showed that providers have adjusted to it, and that the SNF PPS rates have generally covered the cost of care to Medicare beneficiaries.

**2a. Data Sources and Analysis - 29076**

The study used Medicare SNF claims data for calendar year 1999

**Comments:**

As stated on page 29078 “In fact, the ability of the SNF PPS to account adequately for non-therapy ancillary services has been the subject of attention (and a focus of our research) since the very inception of the system.”, we question the accuracy of the claims data in 1999 due to the billing problems associated with consolidated billing and recent edit systems that have resulted in payment adjustments.

We feel that there is not enough accurate data to make an analysis that PPS rates have covered the cost of care, when past adjustments are still being made. We also continue to have concerns with the accuracy of the system to appropriately reimburse SNF’s for overall costs.

**Topic: 2b. Constructing the New RUG-III Groups – (p. 29076/29077)**

First, we found that several of the groups had very few beneficiaries assigned to them. In fact, no beneficiaries at all were assigned to several of the lowest ADL score rehabilitation groups. Second, under the present structure, each Rehabilitation group is sub-divided into three levels based on the activities of daily living (ADL) score. The lowest level ADL score for the Rehabilitation groups is either 4–7 or 4–8, and very few beneficiaries currently classify into those groups. No beneficiaries who would qualify for the proposed newly created groups would classify into such a low ADL score level, as a minimum ADL score of seven is required for classification into an Extensive Care group. Therefore, it appears that stratification for the lowest level ADL scores for the proposed new groups would add needless complexity and, thus, would not be warranted. Instead, we propose to combine that level with the next higher level, and would no longer use the ADL scores lower than 7. Thus, the proposed new groups would be stratified only by two levels of ADL score. For example, the Rehabilitation High plus Extensive Services group would be subdivided into only two ADL levels, ADL scores of 7–12 and 13–18. This left us with only one level for Rehabilitation Low plus Extensive Services and with only two levels at each of the other sub-categories in the new category, for a total of 9 new groups.

**Comments:**

According to the past 3 years of data for our organization, 13-19% of residents classify into the lowest level ADL score for the Rehabilitation groups. It is felt that those numbers are significant compared to your statement that no residents at all were assigned to several of the lowest ADL score rehabilitation groups. With the exception of RUA and RLA, which average less than 1%, our data indicates that a closer look should be taken to consider the effect that the proposed rule will have by re-classifying only those residents with an ADL score of 7 or higher, especially for RMA, RHA and RVA. We feel that it is likely that the residents classifying in the lower ADL categories are likely to also qualify for extensive services. By requiring an ADL score of 7 or higher, the goal of capturing medically complexity for these residents will not be achieved.

**Topic: Table 3a. Crosswalk Between Existing RUG-III Rehabilitation Groups and the Proposed Extensive Plus Rehabilitation Groups (p. 29077)****Comments:**

We request that you review the accuracy of the Table.

In the column for “Current Rehabilitation Groups”, the categories RHC, RHB and RHA are duplicated, listed next to both “Rehab High” and “Rehab Medium” and the categories RMC, RMB and RMA are not listed.

In the column “New combined extensive plus rehabilitation groups”, there is confusion with the 3 letter extensions for each level. For example, the table shows that the Rehab High categories will also be named RUX and RUL, with different ADL scores. Rehab Medium categories will be names RUX and RUL, with different ADL scores, etc.

	Current rehabilitation groups	New combined extensive plus rehabilitation groups
Rehab Ultra .....	<ul style="list-style-type: none"> <li>● RUC-ADL 16-18 .....</li> <li>● RUB-ADL 9-15 .....</li> <li>● RUA-ADL 4-8 .....</li> </ul>	<ul style="list-style-type: none"> <li>● RUX-ADL 16-18 .....</li> <li>● RUL-ADL 7-15 .....</li> </ul>
Rehab Very High .....	<ul style="list-style-type: none"> <li>● RVC-ADL 16-18 .....</li> <li>● RVB-ADL 9-15 .....</li> <li>● RVA-ADL 4-8 .....</li> </ul>	<ul style="list-style-type: none"> <li>● RVX-ADL 16-18 .....</li> <li>● RVL-ADL 7-15 .....</li> </ul>
Rehab High .....	<ul style="list-style-type: none"> <li>● RHC-ADL 13-18 .....</li> <li>● RHB-ADL 8-12 .....</li> <li>● RHA-ADL 4-7 .....</li> </ul>	<ul style="list-style-type: none"> <li>● RUX-ADL 13-18 .....</li> <li>● RUL-ADL 7-12 .....</li> </ul>
Rehab Medium .....	<ul style="list-style-type: none"> <li>● RHC-ADL 15-18 .....</li> <li>● RHB-ADL 8-14 .....</li> <li>● RHA-ADL 4-7 .....</li> </ul>	<ul style="list-style-type: none"> <li>● RUX-ADL 15-18 .....</li> <li>● RUL-ADL 7-14 .....</li> </ul>
Rehab Low .....	<ul style="list-style-type: none"> <li>● RLB-ADL 14-18 .....</li> <li>● RLA-ADL 4-13 .....</li> </ul>	<ul style="list-style-type: none"> <li>● RUX-ADL 7-18 .....</li> </ul>

We presume that this is an error and request that correction to the table be made.

**Topic: 2c. Development of the Case-Mix Indexes – (p. 29077)**

The effect of the increased number of groups and changes in the case-mix indexes should be distributional. By this we mean that the relative weights assigned to each RUG-III group would shift so that the proposed new Rehabilitation plus Extensive groups would have the highest relative weights and the weights for other RUG-III groups would decrease proportionally. The results of applying these methods to index calculation worked well and yielded hierarchically sound indexes for all of the groups; that is, the indexes for the highest groups in the hierarchy are higher than for those below it, and this pattern holds throughout the proposed new category. The nursing indexes in the new category, as well as in the existing rehabilitation category, are naturally more compressed (that is, encompass a smaller range) than those in the 44- group RUG-III rehabilitation groups. The groups within the new Rehabilitation plus Extensive category are more homogeneous than were the rehabilitation groups of the 44-group system. By removing the most clinically complex cases and better accounting for them by putting them in rehabilitation groups of their own, both the resulting proposed new category and the remaining rehabilitation category groups would be more homogeneous and, therefore, the relative weights for each set of groups would exhibit less variance.

**Comments:**

We would like an explanation as to why some of the current rehabilitation categories will experience a decrease in rate. Not all patients who were in those categories will be re-categorized into the new groups, therefore, we will experience a decrease in reimbursement for the same services being provided. Also, the proposed rate for the new category RVL, is LOWER than what we're currently reimbursed for RVB (the equivalent category). In other words, providers will be reimbursed even less, even if the residents qualify for the new RUG. Under any new proposed formula we don't understand how this would be less for a higher category of service. Since this is one of the more common RUG categories we would request that more detailed refinement of be done to help explain the rationale for this phenomena. We don't see how this works with the proposal that "the creation of a proposed new Rehab plus Extensive category would be a means of accounting more accurately for the costs of certain medically complex patients".

**Topic: (p. 29077/29078)**

Next, we simulated payments using the existing weights compared to the new weights to ensure that the refinement did not result in greater or lesser aggregate payments. The simulation results showed an almost exact match in payments under both case-mix models. However, the proposed new 53-group model did yield a slight decrease (less than 1 percent) in aggregate Medicare payments. To remove this minor variance, we then applied a factor of +.02 to calibrate the nursing indexes and re-ran the simulation. Using this calibration factor of +.02, we are able to ensure absolute parity of aggregate payment under the 53-group RUG-III system compared to the 44-group system.

**Comments:**

Although we have a number of concerns about the proposed rule, we are most concerned that the CMS estimate of the revenue neutrality on payments in the proposed rule is inaccurate. Our analysis shows that the proposed rule further reduces payment to SNFs in FY 2006 by about \$5.75 per patient day compared to what they were in FY 2005. This translates to a payment shortfall of an estimated \$400,000 in FY 2006 for our company. We strongly urge CMS to review its calculations and to make any necessary adjustments to correct for the inaccuracy.

Also a part of the revenue neutrality impact of the proposed rule is also predicated on the assumption that CMS will not modify the underlying basis of the SNF PPS, - the use and interpretation of the Minimum Data Set (MDS) in the SNF PPS. The look-back on the MDS into the previous hospital stay allows a facility to important information that allows SNFs to analyze the resident's condition and adequately plan for the appropriate level of care. We estimate that if these steps were taken that an additional \$10-\$12 reduction in the Medicare rates would occur. Elimination of the look-back will impede a nursing facility's ability to develop an appropriate care plan for the resident and penalize facilities that must commit substantial resources within the first few days after admission when patients are most unstable and resource intensive state and require a significant level of skilled nursing care for monitoring and treatment of symptoms related to their stay in the hospital.

The look-back provision was not established to determine that a particular service was delivered but rather to reflect that the types of patients that entered the SNF required more intensive care. Without the look-back provision the SNF will still provide the same level of care, but will not be able to be adequately compensated for that level of ongoing care until the 14-day assessment is undertaken.

**Proposed Refinements to the Case-Mix Classification System – 29078-29081****Topic: (p. 29079)**

As further explained in section II.B.4 of this proposed rule, these additional payments would partially offset the expiration of the temporary add-on payments that will occur, under the terms of section 101(c) of the BBRA, upon the implementation of this proposed case-mix refinement. We believe that implementing the proposed case-mix refinement in this manner will carry out Congressional intent that the BBRA's temporary payment add-ons should not continue indefinitely into the future, while at the same time ensuring that payments under the SNF PPS continue to support the quality of care furnished in this setting.

**Topic: (p. 29080)**

We understand that the expiration of the temporary payment increases, provided for in that legislation, results in a significant reduction in Medicare's payments between FY 2005 and FY 2006. In fact, MedPAC has consistently urged that, until CMS can design a new payment methodology, some or all of the temporary add-on payments be retained and allocated towards beneficiaries with complex medical needs. While this proposed rule sets forth refinements to the existing case-mix classification system and RUG-III categories, we are soliciting comments on the economic impact of the resulting payment changes, as well as their potential impact on beneficiaries' access to quality SNF care. We also invite comments on possible ways in which the case-mix classification system itself might be further modified to help mitigate the effect of the payment changes.

**Comment:**

We completely disagree at this time with the assertion that the temporary add on rates should not be continued. While we support a program to enhance the quality of our residents through a thorough and well designed program modifications, we do not feel that there has been enough consideration taken into account to support this position at this time. We would recommend that all the studies that are currently being done and that are due through the end of this year be completed so that a complete plan be designed and shared with both beneficiary and provider communities.

We are also concerned about the impact of the proposed rule on the financial stability of the long-term care sector, particularly as it relates to nursing homes. By holding aggregate SNF payments in FY 2006 at the same level as in FY 2005, the proposed rule cuts approximately \$510 million from what aggregate SNF payments would have been in FY 2006 without the refinement – i.e. an amount equivalent to the 3 percent market basket update. We are concerned that the implementation of the proposed rule as currently designed will have an undesirable destabilizing effect for numerous providers when the refinement is introduced in the second quarter of FY 2006. As an alternative, we support the proposal by AHCA that recommends that CMS develop an alternative implementation approach that would smooth out or stabilize rates by eliminating the Medicare rate cliff during FY 2006 and thereby help ensure the consistency of SNF payments.

**Topic: (p. 29079/29080)**

One way to accomplish this could be by ensuring that the MDS data used in making such classifications reflect only those services that are actually furnished during the SNF stay itself rather than during the preadmission period (for example during the prior qualifying hospital stay). In the July 30, 1999 SNF PPS final rule (64 FR 41668 through 41669), we noted a public comment that questioned the appropriateness of the MDS's 14-day "look-back" provision in the specific context of the SNF level of care presumption. While we made no revisions to the look-back provision at that time, we specifically reserved the right to reconsider the continued use of this mechanism in the future. Subsequent analysis in this area has focused on the four items contained in the Special Service section of the MDS (P1a—IV medications, suctioning, tracheostomy care, and use of a ventilator/respirator) that serve to classify residents into Extensive Care, the category used for the most medically complex SNF patients under the RUG-III classification system. This analysis indicates that the use of the look-back provision has caused a significant number of residents to classify to the Extensive Services category based solely on services (such as intravenous medications) that were furnished exclusively during the period before SNF admission.

**Comments:**

We understand the reasoning for recording accurate use of services, however, the rationale is driven by reimbursement, and the MDS drives resident assessment, care planning, and quality of care. The look-back period allows the assessor to document all relevant information to adequately complete a plan of care that identifies risks and strengths for each resident. In regards to services, even though a service may have been discontinued prior to admission, there is still a need for ongoing monitoring and assessment. Removing the look-back period would prevent facilities from capturing this higher level of care, as many residents would be placed in lower categories, even though the same amount of resources are being utilized. In turn, facilities would not be adequately reimbursed for those services and the impact would negate the purpose of the 9 new categories. For example, if an IV medication is discontinued prior to admission, there is still a need for ongoing monitoring for recurring symptoms, infection, and possible need to reinstate the treatment. It is also likely that the resident would still be receiving another form of antibiotic, and the acute illness may still be present.

We recommend that CMS not eliminate the look-back period, given the negative impact it would have on quality of assessment and the plan of care.

If the look-back period is removed, we urge you to research alternatives to capture the most medically complex residents. One way this might be accomplished is to revise the requirements for Extensive Service to include other MDS items, and/or combination of items to identify those residents requiring extensive services for an acute condition, many of whom have received IV medications during the hospital stay. For example, item P1e, Monitoring acute medical condition could be combined with items from Section I, Diagnoses, to identify those residents requiring acute monitoring for conditions such as CHF, Hip fracture, Antibiotic resistant infection, pneumonia and other acute infections. This may allow facilities to continue to capture those residents at the highest level of care, as well as better align payments with services that are being provided post-admission. We urge you to research alternatives prior to eliminating the look-back period.

**Topic: (p. 29080)**

We anticipate that this change can be accomplished through an update to the MDS Manual instructions, and will not involve system changes at the facility, State agency, or Federal level.

**Comments:**

In Medicaid Case-Mix states, such as Washington, we do anticipate that such changes would not only create system changes at the facility and State agency levels, but more importantly the proposed refinements will increasingly place our company at greater financial risk.

**Topic: (p. 29080)**

..we have received recommendations to decrease or eliminate the grace day period specifically for the 5-day PPS MDS assessment. We invite comments on this specific recommendation as well as decreasing or eliminating the grace periods associated with all PPS MDS assessments. Another example of a possible policy change on which we invite comment would be whether it might be appropriate to eliminate the projection of anticipated therapy services during the 5-day PPS assessment.

**Comment:**

In the best interest of our residents, and in order to continue to provide quality care, the elimination of projection of anticipated therapy would be detrimental in our efforts to achieve our goal and still receive adequate reimbursement for services provided. There are many instances in which it is in the best interest of the resident to first address other clinical issues (hydration, pain, infection) prior to initiating the full course of therapy. Eliminating the projected therapy minutes would create an incentive for facilities to start ordered therapy immediately, and perhaps not allow the resident adequate time to address other acute conditions. The other possibility is that therapy may be delayed until the observation period for the next assessment, since there would be no reimbursement for therapy services provided. The projected therapy allows the facility and the resident to choose a course of treatment that will provide the resident ample opportunity to succeed, yet provides reimbursement for the services provided during the first 14 days. We feel strongly that if this is eliminated, quality of care is at risk.

Grace days, especially on the 5 day assessments, are important in capturing an accurate level of care for the same reasons mentioned above. At times a resident may refuse therapy, or therapy may be placed on hold, due to other clinical issues or the need for the resident to adjust to their new environment. Grace days can also be utilized when a resident arrives to the facility late in the day. Removing grace days would make it impossible, in some cases, for facilities to receive adequate reimbursement for the care being delivered while keeping the needs of the resident the ultimate priority.

***Topic: Qualifying Three-Day Inpatient Hospital Stay Requirement (p. 29098-29100)***

More recently, it has been suggested that because of changes in hospital admission practices that have occurred since the Congress enacted this provision in 1965, some patients who at that time would have been a hospital inpatient for at least 3 days are instead now placed in observation status initially, before being formally admitted as a hospital inpatient.

These inquiries assert that in such situations, the care furnished during observation may be indistinguishable from the inpatient care that follows the formal admission, so that the beneficiaries themselves often learn of the difference only after they were transferred to the SNF and failed to meet the SNF benefit's prior hospital stay requirement. The inquirers argue that it is unfair to deny SNF coverage to such a beneficiary based solely on what they characterize as a mere recordkeeping convention on the part of the hospital rather than a substantive change in the actual care that the beneficiary receives there.

...with regard to those beneficiaries whose formal admission to the hospital as an inpatient is immediately preceded by time spent in hospital observation status, we invite comments on whether we should consider the possibility of counting the time spent in observation status toward meeting the SNF benefit's qualifying 3- day hospital stay requirement.

**Comment:**

We feel very strongly that this issue has negatively impacted the resident's access to care and services that they are entitled to under Medicare. Our recommendation is that all days spent in the hospital prior to the acute care stay count toward the qualifying hospital stay, including the emergency room and observation unit. The services the resident receives once their care at the hospital begins, should be the same throughout the course of care, regardless of the location within the hospital. The fact that their encounter results in an inpatient stay is sufficient in determining the need for continued skilled care.

It has also been difficult to receive accurate information from the hospital related to the status of the resident at various times from the emergency room through discharge. Often the information or dates of service that we receive is limited and does not specify whether or not the resident was in an observation status. We urge you to look at ways in which this information can be more readily shared amongst providers. There is also a lack of understanding with the discharge planners on the requirements for Medicare in the SNF, which has subsequently resulted in denied coverage.

One way this issue could be resolved would be to rely on the physician certification. If a physician certifies a need for skilled care, regardless of the length of time spent in the hospital, the beneficiary should be entitled to SNF coverage.

CMS should exercise its authority to eliminate the requirement of a 3 day hospital stay for SNF coverage and we thank you for reviewing these concerns.

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## **Closing Comments**

First, we would like to thank CMS for the opportunity to allow us to share our comments concerning the proposed changes to the PPS system.

Currently CMS is trying to resolve the problem of the Medicare PPS payment system. While we support the objectives to set up the system to be fair and responsible to the residents who we care for, we can not support action that just deals with the problems of Medicare reimbursement. Currently the Medicaid system in this country is broken and no one seems to want to take charge and address it. States are allowed to woefully underpay for the services that their clients need and CMS allows this to continue through the approval of the Medicaid programs. We must address the underfunding in the Medicaid system at the same time as we address concerns of the Medicare RUG's refinement. The national average for margins in the Skilled Nursing community is 2.8% and under the current proposal that will only shrink the margins even further. The last time this type of change occurred many SNF companies were forced into bankruptcy and closures.

CMS must also address the proposed changes to the Medicare bad debt system. Currently several states including the state of Washington are allowed to not pick up their share of the co payments for their Medicare residents. Why is it deemed acceptable that the provider should have to pay for this? If the proposed changes in the bad debt system are allowed to stay in place then CMS and the legislature must change the rulings that the state not pick up its responsibility. It is estimated that the proposal will cost the Medicare providers over \$90 million in fiscal year 2006 and that coupled with estimates of the Medicare cliff of \$75 million are not acceptable.

**KEY POINTS:**

*Implementation of the proposed refinement of the case-mix classification system, if implemented in its entirety, will NOT better account for medically complex patients.*

*Based on our data and research, the CMS estimate of the revenue neutrality on payments in the proposed rule is inaccurate.*

*Providers have NOT completely adjusted to SNF PPS, and results of recent edits raise greater concern that rates have NOT covered the total cost of care to beneficiaries.*

*Stratification for the lowest level ADL scores IS warranted for ADL scores lower than 7.*

*Our own simulations, based on data provided by CMS, does NOT show a match in payments under both case-mix models.*

*Temporary add-ons SHOULD continue until further research is completed and a refined case mix classification system will better account for medically complex patients.*

*The look-back period should NOT be removed due to the negative impact on assessment and care planning.*

*The use of grace days should NOT be removed, especially in relation to the 5 day PPS assessment.*

*A SNF specific wage index should be developed to more accurately reflect differences in area wage levels and allow SNF's to request reclassification to alternate, more appropriate local market designations.*

*Considering all of the proposed changes to MDS coding, your presumption that "the groups in this new category would encompass care that is at least as intensive as that identified by any of the upper 26 RUG-III groups under the original, 44-group RUG-II classification system", is incorrect.*

*Your anticipation that "this change can be accomplished through an update to the MDS Manual instructions, and will not involve system changes at the facility, State agency, or Federal level" is incorrect in relation to Medicaid case-mix states, such as Washington.*

*CMS should assist nursing facilities to upgrade and improve their information technology infrastructure by providing funding and technical assistance in order for SNF's to participate in future efforts toward an integrated health delivery system.*

*Time spent in hospital observation status SHOULD count toward meeting the 3 day hospital stay requirement.*

In conclusion, we believe that the proposals could be significantly improved. While we wish to support the concept of RUG refinements, we cannot do so without the whole picture being observed with both Medicare and Medicaid funding for our residents. We wish to work with the agency and provider community to achieve a workable framework for the removal of the add-ons without the elimination of the funding represented by the add-ons. We look forward to continuing to work with CMS in our mutual effort to provide the best possible care for America's frail elderly.

**Submitter :** Ms. Rochelle Archuleta  
**Organization :** American Hospital Association  
**Category :** Health Care Professional or Association

**Date:** 07/12/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

Please see attachment

CMS-1282-P-71-Attach-1.PDF



**American Hospital  
Association**

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July 12, 2005

Mark McClellan, MD, PhD  
Administrator  
Centers for Medicare & Medicaid Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

*Re: CMS-1282-P; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Fiscal Year (FY) 2006; Proposed Rule.*

Dear Dr. McClellan:

The American Hospital Association (AHA), on behalf of our 4,800 member hospitals, health care systems, other health care organizations, and 33,000 individual members, including approximately 1,200 skilled nursing facilities (SNFs), appreciates the opportunity to comment on the fiscal year (FY) 2006 skilled nursing facility prospective payment system (SNF PPS) proposed rule. In addition to recommending a market basket update, the proposed rule includes structural changes to the current payment system and a related termination of payment add-ons, as prescribed by Congress.

We appreciate the attempt by the Centers for Medicare & Medicaid Services (CMS) to more accurately pay for Medicare's sickest SNF patients. The need for such a change has been endorsed by the Medicare Payment Advisory Commission (MedPAC) for several years. We also agree with CMS' recommendation to postpone implementation of these changes until January 1, 2006, which would delay the termination of two payment add-ons needed to address the payment system's failure to fully reimburse nontherapy ancillary services used by Medicare's sickest patients, such as dialysis, respiratory therapy, IV therapy, and laboratory and radiology services.

However, we are concerned that a comprehensive remedy has not yet been developed to correct this fundamental flaw and, therefore, hospital-based SNFs would continue to be disproportionately harmed by the underpayment of nontherapy ancillary services.

Until a comprehensive remedy is available, CMS should adopt measures to provide relief to hospital-based SNFs because they serve a disproportionate share of medically complex patients. **We urge CMS to add an outlier policy to the SNF PPS to support very high-cost patients and a facility adjustment for hospital-based SNFs to support the advanced infrastructure needed to care for complex SNF patients.**

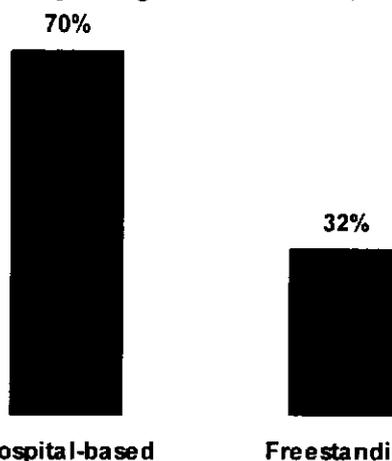
### **Hospital-based SNFs: A Unique Model of Care**

Hospital-based SNFs provide a fundamentally different model of care than freestanding SNFs. In general, hospital-based SNFs treat sicker patients with more skilled personnel in half the time used in freestanding SNFs. The scope and intensity of services provided by hospital-based SNFs is more advanced and, therefore, more costly. Both the SNF PPS per diem structure and its underpayment of nontherapy ancillary services impose significant and unjustified disadvantages on hospital-based SNFs treating sicker patients requiring more extensive services during a concentrated period. This model of care is clinically valuable for medically complex Medicare beneficiaries and must be preserved.

#### **Hospital-based SNFs Treat Complex Patients Needing More Nontherapy Ancillary Services**

Research shows that hospital-based SNFs care for a greater proportion of complex Medicare patients than freestanding SNFs. An in-depth analysis of Medicare SNF claims found a significantly different patient mix in hospital-based SNFs in comparison to freestanding facilities. Seventy percent of hospital-based SNF patients have four or more major diagnostic conditions. Only 32 percent of freestanding SNF patients had the same complexity.

**Percent of SNF patients with four or more major diagnostic conditions, 1999**



Source: Liu, K and Black K. "Hospital-based and Freestanding Skilled Nursing Facilities: Any Cause for Differential Medicare Payments?" *Inquiry* 40:94-104, Spring 2003.

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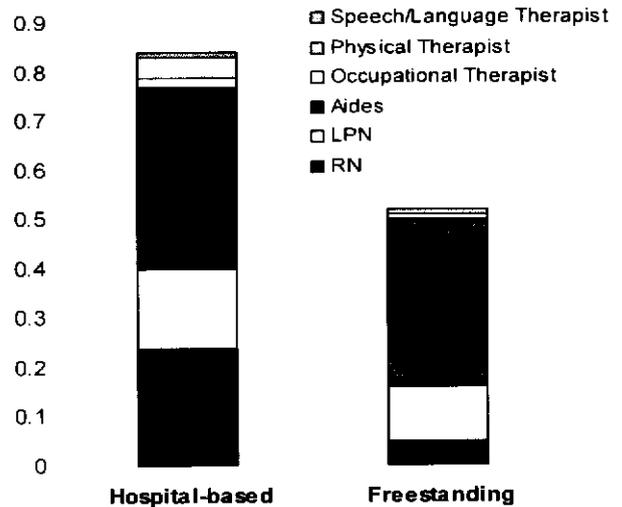
### Hospital-based SNFs Employ More Skilled Staff

Hospital-based SNFs employ a highly skilled workforce to ensure a more advanced clinical capacity to address the needs of their complex patients. Hospital-based SNFs have a higher staffing ratio per bed than freestanding facilities. In addition, hospital-based SNFs use more registered nurses (RNs) and licensed practical nurses (LPNs) in their mix of staff per patient bed, while freestanding facilities use more aids in their staff mix per patient bed.

Not only are hospital-based SNFs a unique model of care, they are also unique in their financial treatment by Medicare. They have been disproportionately harmed by the SNF PPS due to its under-reimbursement of nontherapy ancillary services. Medicare margins for hospital-based SNFs clearly demonstrate the financial strains the PPS has created. According to MedPAC, the aggregate Medicare margin for hospital-based SNFs in 2003 was *negative* 87 percent compared to a positive 13 percent margin for freestanding facilities. Since the implementation of the PPS, Medicare margins for hospital-based SNFs have steadily declined despite temporary financial add-ons and a shorter patient length of stay. MedPAC has repeatedly recommended that CMS reallocate Medicare funds to the resource utilization groups (RUGs) associated with more medically complex patients.

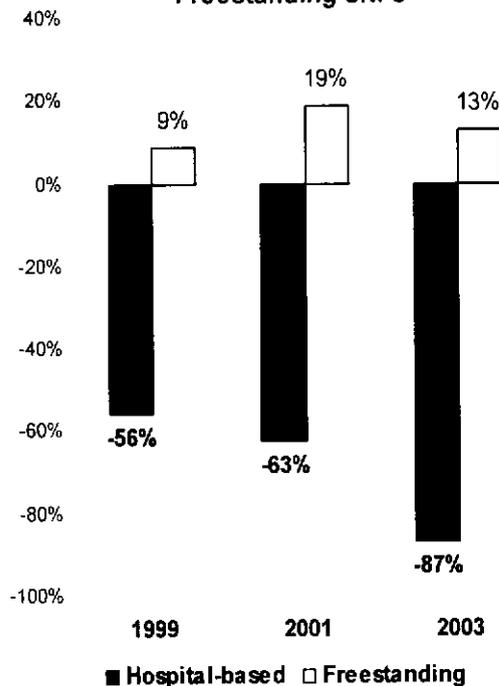
Unsustainable losses resulting from the PPS have forced many hospital-based SNFs to close. The number of hospital-based SNFs decreased by 33 percent between 1998 and 2003. Without action to fully cover the cost of treating medically complex patients using nontherapy ancillaries, hospital-based SNF closures will continue – jeopardizing access for some of Medicare’s sickest patients.

Median Number of Staff Per SNF Bed, 1999



Source: Liu, K and Black K. "Hospital-based and Freestanding Skilled Nursing Facilities: Any Cause for Differential Medicare Payments?" Inquiry 40:94-104. Spring 2003.

Medicare Margins for Hospital-based and Freestanding SNFs



Source: MedPAC Data Book, June 2004, MedPAC December 2004 Meeting Transcripts and MedPAC March 2004 Report.

### Hospital-based SNFs Spend Less on Overhead per Medicare Dollar

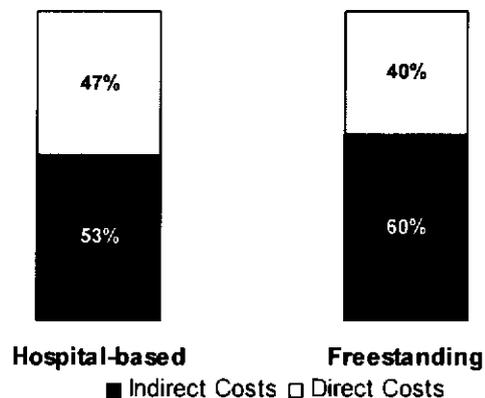
The allocation of a hospital's overhead (indirect) costs to all departments, including the skilled nursing unit, has been cited as the cause of negative Medicare margins for hospital-based SNFs. Indirect costs include laundry, housekeeping, dietary, cafeteria, social services, medical records, and other important services that are essential to patient care. Because of their size and complexity, hospitals generally experience higher overhead costs than other health care settings. As a result, it has been presumed that post-acute care providers in hospitals have higher overhead costs than freestanding facilities.

An independent analysis of 2001 Medicare cost reports by Clark, Koortbojian & Associates Inc. found an average \$264 per diem cost per day for all patients in a hospital-based SNF in comparison to the \$139 average per diem cost per day for patients in a freestanding facility.

However, the same analysis revealed that hospital-based SNFs have a lower percentage (53 percent) of overhead indirect costs than their freestanding counterparts (60 percent). This means that **hospital-based SNFs spend less on overhead per Medicare dollar than freestanding SNFs.**

The primary drivers of the higher overall cost per day for hospital-based SNFs are not indirect overhead costs, but the direct costs related to their higher staff skill mix, greater staff-to-patient ratio, and the number of advanced services provided. These clinical attributes are directly related to the greater medical complexity of the patients served in hospital-based SNFs. **The striking downward trend for hospital-based SNF Medicare margins, as estimated by MedPAC, is clearly *not* being caused by a corresponding increase in the allocation of a hospital's overhead costs to a co-located SNF.**

Percent of Total Costs for SNFs, 2001



Source: Clark, Koortbojian & Associates Inc. Analysis of 2001 SNF Cost Reports, 2004.

**Congress Supports Care For Medically Complex SNF Patients**

Congress first expressed its concerns about access for medically complex SNF patients through two legislative measures. Through the Balance Budget Refinement Act of 1999 (BBRA), Congress authorized a 20 percent increase in the per diem rates for 15 RUGs — the SNF payment unit — to be in effect until “the later of: (1) October 1, 2000, or (2) implementation of a refined case mix classification system ... that would better account for medically complex patients.” BBRA also authorized a two-year, across-the board payment add-on of 4 percent.

Under the Benefits Improvement and Protection Act of 2000 (BIPA), Congress directed CMS to study alternative systems for categorizing Medicare SNFs patients according to their relative resource use. BIPA also authorized a temporary add-on of 16.66 percent to the nursing component of each RUG and reduced the 20 percent add-on to 6.7 percent for selected rehabilitation RUGs.

**CMS has neither released the study called for under BIPA nor has it proposed a specific remedy to address the primary cause of access problems for medically complex SNF patients – underpayment of nontherapy ancillary services.** Instead, as stated in the proposed rule, CMS determined that “even case-mix refinements of a more incremental nature would meet BIPA’s more targeted mandate to better account for medically complex patients, and CMS need not await the completion of the broader changes envisioned in the BIPA provision.” To justify this position, CMS notes that MedPAC estimates that the cost of care for Medicare beneficiaries has been “generally covered” by the SNF PPS as indicated by positive Medicare margins for freestanding SNFs. **The proposed rule does not recognize the significantly different financial picture for hospital-based SNFs, which have endured dramatically negative Medicare margins.**

While the Congressionally mandated payment add-ons have not completely offset the fundamental challenges experienced by hospital-based SNFs, they have provided welcome relief. Under the proposed rule, the \$1.4 billion in annual add-on funds would be partially restored by an annual \$700 million nursing component add-on. **Without other measures, the resulting \$700 million loss in annual funding will place hospital-based SNFs in an even more precarious financial situation, and would ultimately be detrimental to the medically complex Medicare patients they treat.**

**Proposed Refinements to the Case-mix Classification System**

CMS proposes to refine the SNF PPS by maintaining the general structure of the current payment system, while adding new payment categories to capture complex and costly patients who presently receive both extensive services and rehabilitation therapy. The proposed rule would create a new RUG category – Combined Rehabilitation and Extensive Care – to consist of nine new RUGs. The new RUG category would have the highest relative weights within the SNF PPS while other RUG weights would be decreased proportionally. CMS predicts that by removing the most clinically complex cases and accounting for them in a group of their own,

both the new and remaining RUG categories would be more homogeneous. However, the payment system's predictive power would only marginally improve as a result of the new RUGs.

CMS found wide variability in non-therapy ancillary utilization within each RUG and across all 44 RUGs. Data show great variability in ancillary services utilized by different SNF residents grouped within the same RUG. CMS also found that patients classified into a less-intensive RUG may still receive significantly more expensive non-therapy ancillary services than patients in a more intensive RUG. The proposed rule recognizes that CMS cannot adequately explain these discrepancies within and across RUGs and that the addition of nine new RUGs does not eliminate or compensate for the discrepancies. The regulation further notes that the SNF PPS is the only Medicare prospective payment system that lacks an outlier component to capture high variability in resource utilization.

To address this high degree of variability in non-therapy ancillary utilization within and across the RUGs, CMS is proposing an across-the-board increase to the nursing component of the case-mix weights for all 53 RUGs. The amount of the adjustment equates to approximately 3 percent of aggregate expenditures under the SNF PPS. CMS views this adjustment as a proxy for a non-therapy ancillary index — an element that was previously considered but found to add substantial complexity to the payment system. CMS is refraining from increasing the number of payment groups to capture different levels of non-therapy ancillary use, although other Medicare payment systems have significantly greater groups of payment categories than the currently proposed 53 RUGs.

Under the proposed rule, the current 44 RUGs and payment add-ons would continue to be in effect for the first quarter of FY 2006 (October through December 2005). However, beginning Jan. 1, 2006, the 53 new SNF PPS RUGs would take effect along with the proposed nursing component payment add-on.

### **Recommendations**

We believe the core problem with the current SNF PPS and the proposed rule is the failure to fully reimburse hospital-based SNFs for the nontherapy ancillary services they provide. On average, the higher acuity caseloads in hospital-based SNFs require more nursing time and nontherapy ancillary services than freestanding facilities, as indicated in the charts below. Ancillary costs contribute to a large percentage of total Medicare costs for both hospital-based SNFs (32 percent) and freestanding SNFs (38 percent). However, **nontherapy ancillaries comprise a much greater proportion of total ancillary costs (57 percent) for hospital-based SNFs than for freestanding SNFs (39 percent)**. Therefore, underpayment of nontherapy ancillary services harms hospital-based SNFs to a greater degree. Yet these facilities must still bear the costs associated with maintaining the personnel and infrastructure needed to deliver these critical services.

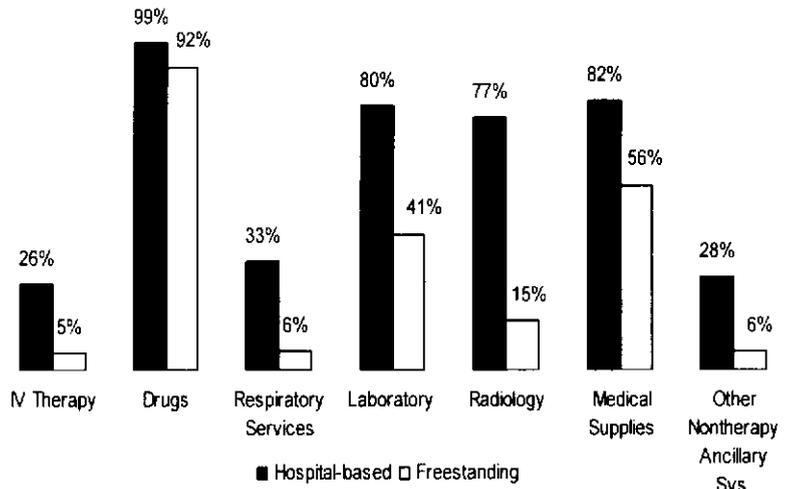
It is clear that in addition to the proposals to add nine new RUGs and implement a nursing component add-on, additional remedies are needed to address the chronic underpayment of nontherapy ancillary services by the SNF PPS. The proposed rule acknowledges that CMS currently has a very limited ability to address this problem, which resulted in the proposal to

Mark McClellan, MD, PhD  
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apply an across-the-board increase to the nursing component of the RUGs. While this measure to increase aggregate payments is appreciated, it would not fundamentally improve the ability of the payment system to predict which patients, within and across payment categories, are more likely to use high-cost nontherapy ancillary services.

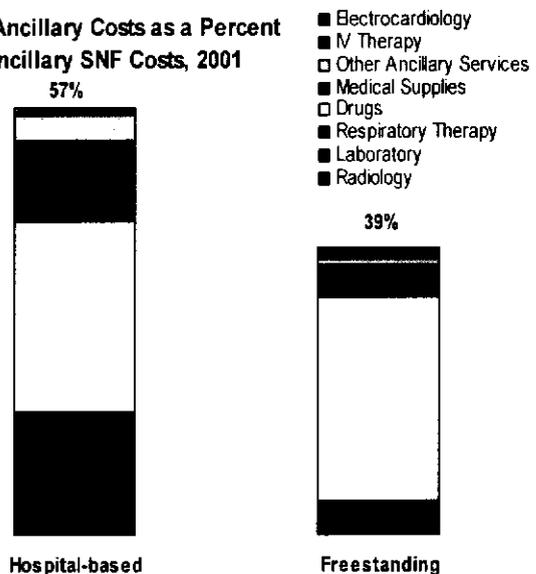
Further, the proposed rule notes that the addition of nine new payment categories would only minimally increase the current payment system's low predictive ability (from an r-square of 4.1 percent to 9.5 percent). Therefore, under the proposed rule, underpayment of nontherapy ancillaries would persist and the overall financial situation would become more challenging because the current \$1.4 billion in payment additions would be only partially offset by the proposed across-the-board payment add-on. Until a more targeted and effective remedy is available, hospital-based SNFs will continue to struggle with restrictions on their ability to serve the sickest Medicare beneficiaries. More must be done in the interim to assist SNFs treating these patients.

Percent of Patients Using Ancillary Services in Hospital-based vs. Freestanding SNFs, 1999



Source: Liu, K and Black K. "Hospital-based and Freestanding Skilled Nursing Facilities: Any Cause for Differential Medicare Payments?" Inquiry 40:94-104, Spring 2003.

Nontherapy Ancillary Costs as a Percent Total Ancillary SNF Costs, 2001



Source: Clark, Koorboojian & Associates Inc. Analysis of 2001SNF Cost Reports, 2004.

Specifically, the AHA recommends that CMS implement a hospital-based SNF facility adjustment to support the medical infrastructure needed to care for beneficiaries in need of advanced skilled nursing. The adjustment would recognize the costly personnel, equipment, and other operational features that must be maintained to provide proper care for medically complex patients. This measure would provide needed relief until a comprehensive fix for underpayment of nontherapy ancillary services is available and implemented.

Medicare should also support the ability of hospital-based SNFs to continue providing their distinct model of care, which focuses on recuperation and restoration of function rather than on residential services. This approach is clinically beneficial and appealing to many beneficiaries who do not require ongoing institutional care and want to return to the home setting as soon as possible. Hospital-based SNFs have an average length of stay (ALOS) that is half (13 days) that of freestanding facilities (27 days). Providing care in a more concentrated period of time is facilitated by a greater presence of skilled staff and advanced equipment and technology that raise the intensity and quality of care. While the average per diem cost for hospital-based SNF patients is higher than for patients in freestanding facilities because of the more advanced services provided, the *overall* cost to Medicare for the patient's entire stay is lower because of the significantly shorter ALOS for the hospital-based setting.

Because the SNF PPS is a per diem-based system, hospital-based SNFs experience a clear financial disadvantage when they provide care in half the amount of time than their freestanding counterparts even though many Medicare patients clinically benefit from the more intensive care provided in the hospital-based setting. Further, measures beyond those in the proposed rule are needed to enable hospital-based SNFs to continue delivering care using this clinically valuable model without a financial penalty. To help sustain this distinct model of care, **AHA urges CMS to create an outlier pool equal to 2 percent of SNF payments. An outlier payment will help minimize access problems for the most costly patients who are often difficult to place.** All other prospective payment systems in the Medicare program include an outlier policy and the SNF PPS is in desperate need of this additional protection. Funding of the outlier pool should be done in a budget neutral manner.

**CMS should also consider weighting the per diem payment through variable per diem adjustments, as applied in the inpatient psychiatric facility PPS,** which would pay a higher daily rate for the early days of a patient stay rather than the later days. This approach would be a good fit for the SNF PPS because the early days of a SNF stay are the most expensive. This would provide an incentive to treat sicker, short-stay patients and help address the documented problem of limited access to care for these patients.

**Because our recommendations would add new features to the SNF PPS that could be implemented using several different methodologies, AHA also urges CMS to issue an interim final rule with the proposed measures to better address the high costs of medically complex patients.** Issuing an interim final rule would allow AHA and others to provide valuable input and refinements to any proposed changes in the measures to protect access to the most complex and costly patients. Additionally, an interim final rule would allow CMS to implement the PPS refinements under its proposed time frame of January 2006, while implementing the market basket update beginning Oct. 1, 2005.

#### **MDS Procedural Changes Should Not Be Considered in Isolation**

The minimum data set (MDS) items presented for discussion in the proposed rule should not be acted upon in a piecemeal fashion. CMS already has a process underway to update the current 2.0 version of the MDS, which has been the subject of ongoing discussions between CMS and

national stakeholders in order to ensure that the pending revision effectively captures the concerns of CMS, providers and patients. All MDS changes should be conducted in a coordinated fashion with regard to the development of MDS 3.0 and a broader refinement of the SNF PPS. The potential MDS modifications identified in the proposed rule, such as the "look-back" period, grace days, and anticipated therapy, would be very detrimental because they would significantly limit the cases that would be eligible for the proposed new RUGs categories. Hospital-based SNFs would not have the wherewithal to bear these proposed MDS restrictions in combination with continued underpayment for nontherapy ancillary services. Any proposed changes should be presented with full analysis of their implications for patients and providers through formal rulemaking that allows for review and comment.

Also, as noted in the past, the AHA continues to be concerned about the MDS' inability to capture short-stay patients discharged before the standard five-day assessment. These types of patients are commonly treated in hospital-based SNFs.

#### **AIDS Payment Add-on Should be Extended**

The AHA strongly supports the CMS proposal to extend the 128 percent add-on payment for AIDS patients. This is a highly vulnerable patient population that should be ensured access to SNF care.

#### **Proposed Revision of Geographic Classifications**

To mitigate excessive changes in the wage index adjustments for SNFs, the change from metropolitan statistical areas (MSAs) to core-based statistical areas (CBSAs) should be phased in using the parameters applied to general acute hospitals. That is, in FY 2006, SNFs that experience a drop in their wage index because of the adoption of the new labor market areas would have their wage index adjustment applied based on a 50-50 blend under the MSA and CBSA indices. As also allowed for general acute hospitals, SNFs previously located in an urban MSA that would fall into the rural category under the CBSA definitions, would be assigned the wage index value of the urban area to which they previously belonged. This transition should be applied in a budget-neutral manner.

#### **Other Issues**

##### **CMS Should Share Data and Analyses**

It would have been very helpful for providers and organizations such as ours if the proposed rule would have been released along with the data and analyses used by CMS to develop the provisions in the proposal, especially for those designed to restructure the RUGs. Specifically, it would have been helpful if CMS had released the full Urban Institute report rather than providing a mere summary of the report. Also, a detailed impact file with provider numbers would provide a greater means of estimating the impact of the proposed rule at the provider and national levels, which would in turn contribute to more robust feedback to CMS on how to strengthen the proposal. Without this data, stakeholders lack the key tools to assess the proposed rule and develop comprehensive, informed comments.

Mark McClellan, MD, PhD  
July 12, 2005  
Page 10 of 10

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**Three-day Inpatient Hospital Stay Requirement**

While not proposing a specific change to the current policy for counting hospitals days to establish eligibility for Medicare SNF coverage, the proposed rule does ask for input on whether hospital observation days should be included. Presently, hospital observation days do not count toward the requirement that only patients with a prior hospital stay of at least three days are eligible for Medicare SNF coverage. Patients often receive a full range of services during the observation phase. Therefore, there is no reason to exclude observation days from this count. As such, **the AHA would support counting hospital observation days towards the fulfillment of the SNF prior hospitalization requirement, as allowed under current statute.**

We appreciate the opportunity to comment on this proposed rule, and we encourage CMS to continue to actively pursue a remedy to the fundamental flaw of the SNF PPS: underpayment of nontherapy ancillary services. We look forward to collaborating with CMS to achieve this goal. For more information about these comments, please contact Rochelle Archuleta, AHA senior associate director of policy, at (202) 626-2320.

Sincerely,



Rick Pollack  
Executive Vice President

Submitter :

Gail Goss

Date: 07/12/2005

Organization :

Masonic Village of Elizabeth

Category :

Long-term Care

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

**Issue**

Issue

see attachment

Proposed Refinements to the Case-Mix Classification System

see attachment

CMS-1282-P-72-Attach-1.RTF

Reply to CMS File code CMS1282-p  
Case-mix adjustments and other clinical issues  
Proposed refinements to the case-mix classification system

This response addresses the following areas of concern

1. Nine new RUGs
2. Changing the look back period for MDS question P1. Special Treatments, Procedures and Programs
3. Eliminating Grace Days
4. Eliminating Section T1. Rehab day and minute projections

Research cited by CMS confirms the wide variability in non-therapy ancillary expenses and the need to better account for them. The 20% and 6.7% add ons also confirm the inadequacy of the PPS reimbursement system. The proposed nine new RUG case mix refinement does not fix the problem. The data to support this refinement is very old (Staff time measurement studies conducted in 1990, 1995 and 1997) and the studies conducted only improve the variance from 4.1% to 9.5 %. This still leaves 90% of the variation unexplained.

The proposal to eliminate the 14 day look back period into the hospital stay (question P1) will further negate the intended effect of the case mix refinements. These services delivered in the hospital substantially contribute to the number of residents who fall into the SE category. These services (IVs, IV medications, Ventilators, etc) are markers of significant illness that require intensive observation and care within the first week of admission into a SNF. These are not captured by other RUG questions on the MDS. The look back into the hospital should remain for reimbursement and a means to identify treatments that increase risk factors of nosocomial infections such as pneumonia and complications of phlebitis, etc. and their subsequent treatment in the SNF.

Eliminating grace days would further increase the gap between payment and actual services provided. With this elimination, the 5 day assessment ARD can only be set on days 1-5. Day one admissions to the SNF from hospitals are generally in the late afternoon and resident fatigue from the stress of hospital discharge and transportation to the SNF usually precludes any rehabilitation therapy on day one. Rehabilitation starting on day two eliminates any possibility of obtaining 5 days of one type of therapy. Therefore the resident could not fall into the Rehab Ultra High or Very High group. If the T1 projection is eliminated, the resident would not fall into the High group. Rehab medium could only be obtained if two therapies are given days 2-5. Only specific diagnosis and conditions warrant two different therapies. The most intensive therapy is usually given within the first two weeks of admission. Eliminating the grace days would not reimburse SNFs for the actual services provided and would in fact default to the lower reimbursement categories of clinically complex and reduced physical functioning. Rehab Very High and Ultra High could only be obtained if a geriatric resident attends therapy on the first day of admission to a SNF, for 5 consecutive days and a minimum of 1.6 to 2.4 hours a day. That is a brutal schedule for a sick geriatric resident. Furthermore,

a 5 day look back period eliminates any possibility of a rehab low category, because 6 days of restorative nursing is required. The MDS look back period for this section is 7 days and 7 days of data can be collected with the grace days. This allows facilities to accurately capture the minutes and days of therapy administered to the resident. The grace days are also needed for day 14 and 30 assessments since they fall so close to each other and within the first month of admission.

Eliminating the T1 projection on the 5 day PPS assessment along with the elimination of grace days will exclude almost all residents falling into any rehab category even though they will receive this service during the first two weeks after admission to the SNF. The intent of the T1 projection was to allow time for frail residents to gain strength and slowly increase therapy time so therapy can be successful. Again this elimination would further widen the gap between services rendered and reimbursement.

It is strongly recommended to

1. Keep the RUGs as they now stand
2. Keep the P1 look back period in the hospital.
3. Keep grace days for the 5, 14, and 30 day PPS assessments since they occur within the first month of admission.
4. The grace days for the 60 and 90 day assessments could be eliminated since most residents are stable and there is little variation in the treatment plan by the second month.
5. Do not eliminate the T1 projection.

Submitted by;

Gail Goss RN, BS

Assistant Director of Nursing, Clinical Information Specialist

Masonic Village of Elizabethtown

Elizabethtown, Pa. 17022

**Submitter :** Mr. Wade Stubson  
**Organization :** Eventide Lutheran Home  
**Category :** Long-term Care

**Date:** 07/12/2005

**Issue Areas/Comments**

**Issue**

**Wage Index Data**

The BBA provides that the area wage index applicable to hospitals located in an urban area of a State may not be less than the area wage index applicable to hospitals located in rural areas of the State (the "rural floor" rule). As such, if a hospital MSA wage index is less than the rural index of their State, the higher rural index is applied. Past policy has not provided this same option for providers of SNF services. It seems only logical and fair that the same provision apply to SNF's as well and that Skilled Nursing Facilities also be allowed the GREATER of the wage index for their specific MSA OR the rural wage index for that State. Hospitals and SNF's in the same MSA do compete for similar medical personnel and, under the current application of this rule, hospitals are granted a significant financial advantage when they are allowed to apply the higher rural wage index and SNF is not.

Submitter : Ms. Nancy McLean  
 Organization : CHRISTUS St. Joseph Villa  
 Category : Nurse

Date: 07/12/2005

#### Issue Areas/Comments

##### Issue

##### Issue

While AHCA disagrees with elimination of the look-back period on the 5 day assessment as a Director of Nursing I do not believe this would negatively impact the nursing care given including the monitoring and observation. I believe that the professional nurse will still receive report from the hospital nurse and will develop a plan of care to meet the needs of the patient based on a professional assessment. I do not feel that elimination of the hospital look-back will negatively affect the care of the resident or the re-imburement received if we are following a plan of care in the SNF that meets the Standards of Care for patients with a history of IVs, Vents. We should be able to capture the increased nursing care required within the first 8 days through the documentation in the medical record.

My major concern in the propose rule is the elimination of Grace days. Elimination of the Grace days on the 5 day assessment would negatively impact not only reimbursement but the ability to recruit and retain physical and occupational therapy staff. CMS needs to realize the impact of the DRG system, reduced days and focus by hospital administration on avoidable days. Physicians in hospitals are pressured to discharge patients daily. These discharges often occur late in the day after the physician has made rounds, written the discharge order, the case manager has arranged SNF placement, the nurse has called report, notified the family and transportation has been arranged. Over 75% of the patients received by the facilities I have worked in for the past 5 years have arrived after 2pm. The admission day is Day 1 on the MDS. Day 1 is LOST to us in most cases. Elimination of the grace days would result in 4 days data. Patients admitted on Friday, our highest admission day, may not receive therapy until Monday depending on the case load already in place for the Saturday therapist. That gives us 2 days to capture the level the patient will be truly at.

Elimination of the grace days on the 5 day will condemn therapy staff to every week-end coverage. (We have been trying to recruit an Occupational Therapist unsuccessfully for 3 months. I only see this exacerbating that problem and wonder how many CMS staff work week-ends.) An accurate assessment for therapy minutes is often impossible on the 5 day given these common circumstances.

Elderly patients arriving from the hospital who have undergone any surgical procedure requiring anesthesia are often confused and/or present with anesthesia induced delirium. These patients are often uncooperative with therapy in the early days of admission but become more cognitive with time and patience. Use of grace days on the 5 day allows for improved cognition over the 8 days and better capturing what the patient will actually be able to tolerate toward the end of the 15 day payment period. In summary the use of the grace days on the 5 and 14 day assessments are necessary for accurate coding and estimation. It is highly unlikely that accuracy of data captured for the 30, 60 or 90 day assessments would be improved by use of grace days for these assessments. Elimination of grace days on these assessments would not adversely impact the facility or the plan of care.

##### Concurrent Therapy

I have observed therapy numerous times and worked with many therapists. Therapists are professionals, they know there practice act and limitations. Concurrent therapy decisions should be left to the discretion of the professional therapist. They know when they can start one modality as before they finish another. Why sit and stare at someone with 'hot packs' in place to loosen joints prior to therapy if you can be providing therapy to someone else.

##### Case-Mix Adjustment and Other Clinical Issues

Finally, CMS has ignored the burden placed on the SNF through the PPS system under the Balanced Budget Act. CMS has left it up to the individual SNF to negotiate payment for patient required services outside of the SNF, other then the listed exclusions, with other providers. There lack of support in this area is unconscionable. Medicare establishes rates for reimbursement controlling SNF's, providers and hospitals. CMS should mandated that the maximum charged to SNF's by participating hospitals and providers be no more than the Medicare prevailing rates. Many hospitals have viewed SNF's as a source of income rather than a partner struggling to provide quality of care with the same and often more financial and CMS restrictions they are facing.

##### Case-Mix Adjustment and Other Clinical Issues

Qualifying 3 day hospital stay. I believe that CMS in making changes should strongly consider elimination of this requirement. I have personally received phone calls from emergency rooms requesting admission to Medicare for patients who do not require a hospital stay but who cannot return home alone. (This was a major concern in Florida where many couples moved for retirement, away from other family support. One spouse dies and the remaining spouse remains home alone.) They present with such diagnoses as UTI accompanied by delirium, fractured pelvis, falls with sprains and strains, fractures upper limb. Many of these do not require a 3 day hospital stay but could benefit from evaluation by therapy of why they fell and strengthening through PT to prevent further falls as well as OT training for ADL completion. Elimination of the 3 day stay would result in overall cost saving to Medicare in many cases. Elimination of the stay could be accompanied by a list of acceptable diagnoses/conditions for direct admission to a SNF from an ER or physician's office.

##### EXCLUSIONS

CMS should consider revision of the rule for Chemotherapy and Radiation as exclusions only if provided by a hospital based facility. There are no hospital based radiation facilities in many areas of the country, i.e. Sarasota, Florida. Exclusions should be procedure based regardless of location received. CMS should consider Wound Treatment centers, including hyperbaric centers as an exclusion. While nursing homes have become specialists in wound care this is not easily recognized by community surgeons and infectious disease physicians. Consequently they believe they must control treatment and return patients to hospital based clinics. The expense for these treatments falls to the SNF as well as the expense of transportation.

**Submitter :** Mrs. KAREN LEBOW  
**Organization :** FAIR VIEW TRANSITIONAL HEALTH CENTER  
**Category :** Long-term Care

**Date:** 07/12/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

SEE ATTACHMENT

CMS-1282-P-75-Attach-1.DOC

**CMS-1282-P**

**Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006**

Submitter

FairView Transitional Health Center.

Date: July 12 , 2005

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Thank you for the opportunity to submit comments on this proposed rule. As requested, the following comments are organized by referencing the identifier that precedes the section, as well as the page number.

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**Case-Mix Adjustment and Other Clinical Issues – 29075-29078**

**Topic: (p. 29075)**

This legislation specified that the payment adjustments would continue until the later of: (1) October 1, 2000, or (2) implementation of a refined case-mix classification system under section 1888(e)(4)(G)(i) of the Act that would better account for medically complex patients.

**Comments:**

We disagree that the implementation of this refined case-mix classification system would better account for medically complex patients, and feel that the proposed refinement is somewhat premature. We have great concern that the proposed rule will have a negative impact on our nursing homes in regards to financial stability and quality of resident care. We ask that you carefully consider our comments.

**Topic: (p. 29076)**

Moreover, ongoing analysis of the SNF PPS showed that providers have adjusted to it, and that the SNF PPS rates have generally covered the cost of care to Medicare beneficiaries.

**2a. Data Sources and Analysis - 29076**

The study used Medicare SNF claims data for calendar year 1999

**Comments:**

As stated on page 29078 "In fact, the ability of the SNF PPS to account adequately for non-therapy ancillary services has been the subject of attention (and a focus of our research) since the very inception of the system.", we question the accuracy of the claims data in 1999 due to the billing problems associated with consolidated billing and recent edit systems that have resulted in payment adjustments.

We feel that there is not enough accurate data to make an analysis that PPS rates have covered the cost of care, when past adjustments are still being made. We also continue to have concerns with the accuracy of the system to appropriately reimburse SNF's for overall costs.

**Topic: 2b. Constructing the New RUG-III Groups – (p. 29076/29077)**

First, we found that several of the groups had very few beneficiaries assigned to them. In fact, no beneficiaries at all were assigned to several of the lowest ADL score rehabilitation groups. Second, under the present structure, each Rehabilitation group is sub-divided into three levels based on the activities of daily living (ADL) score. The lowest level ADL score for the Rehabilitation groups is either 4–7 or 4–8, and very few beneficiaries currently classify into those groups. No beneficiaries who would qualify for the proposed newly created groups would classify into such a low ADL score level, as a minimum ADL score of seven is required for classification into an Extensive Care group. Therefore, it appears that stratification for the lowest level ADL scores for the proposed new groups would add needless complexity and, thus, would not be warranted. Instead, we propose to combine that level with the next higher level, and would no longer use the ADL scores lower than 7. Thus, the proposed new groups would be stratified only by two levels of ADL score. For example, the Rehabilitation High plus Extensive Services group would be subdivided into only two ADL levels, ADL scores of 7–12 and 13–18. This left us with only one level for Rehabilitation Low plus Extensive Services and with only two levels at each of the other sub-categories in the new category, for a total of 9 new groups.

**Comments:**

According to the past 3 years of data for our organization, 13-19% of residents classify into the lowest level ADL score for the Rehabilitation groups. It is felt that those numbers are significant compared to your statement that no residents at all were assigned to several of the lowest ADL score rehabilitation groups. With the exception of RUA and RLA, which average less than 1%, our data indicates that a closer look should be taken to consider the effect that the proposed rule will have by re-classifying only those residents with an ADL score of 7 or higher, especially for RMA, RHA and RVA. We feel that it is likely that the residents classifying in the lower ADL categories are likely to also qualify for extensive services. By requiring an ADL score of 7 or higher, the goal of capturing medically complexity for these residents will not be achieved.

**Topic: Table 3a. Crosswalk Between Existing RUG-III Rehabilitation Groups and the Proposed Extensive Plus Rehabilitation Groups (p. 29077)****Comments:**

We request that you review the accuracy of the Table.

In the column for “Current Rehabilitation Groups”, the categories RHC, RHB and RHA are duplicated, listed next to both “Rehab High” and “Rehab Medium” and the categories RMC, RMB and RMA are not listed.

In the column “New combined extensive plus rehabilitation groups”, there is confusion with the 3 letter extensions for each level. For example, the table shows that the Rehab High categories will also be named RUX and RUL, with different ADL scores. Rehab Medium categories will be named RUX and RUL, with different ADL scores, etc.

	Current rehabilitation groups	New combined extensive plus rehabilitation groups
Rehab Ultra .....	<ul style="list-style-type: none"> <li>● RUC-ADL 16-18. ....</li> <li>● RUB-ADL 9-15. ....</li> <li>● RUA-ADL 4-8. ....</li> </ul>	<ul style="list-style-type: none"> <li>● RUX-ADL 16-18.</li> <li>● RUL-ADL 7-15.</li> </ul>
Rehab Very High .....	<ul style="list-style-type: none"> <li>● RVC-ADL 16-18. ....</li> <li>● RVB-ADL 9-15. ....</li> <li>● RVA-ADL 4-8. ....</li> </ul>	<ul style="list-style-type: none"> <li>● RVX-ADL 16-18.</li> <li>● RVL-ADL 7-15.</li> </ul>
Rehab High .....	<ul style="list-style-type: none"> <li>● RHC-ADL 13-18. ....</li> <li>● RHB-ADL 8-12. ....</li> <li>● RHA-ADL 4-7. ....</li> </ul>	<ul style="list-style-type: none"> <li>● RUX-ADL 13-18.</li> <li>● RUL-ADL 7-12.</li> </ul>
Rehab Medium .....	<ul style="list-style-type: none"> <li>● RHC-ADL 15-18. ....</li> <li>● RHB-ADL 8-14. ....</li> <li>● RHA-ADL 4-7. ....</li> </ul>	<ul style="list-style-type: none"> <li>● RUX-ADL 15-18.</li> <li>● RUL-ADL 7-14.</li> </ul>
Rehab Low .....	<ul style="list-style-type: none"> <li>● RLB-ADL 14-18. ....</li> <li>● RLA-ADL 4-13. ....</li> </ul>	<ul style="list-style-type: none"> <li>● RUX-ADL 7-18.</li> </ul>

We presume that this is an error and request that correction to the table be made.

**Topic: 2c. Development of the Case-Mix Indexes – (p. 29077)**

The effect of the increased number of groups and changes in the case-mix indexes should be distributional. By this we mean that the relative weights assigned to each RUG-III group would shift so that the proposed new Rehabilitation plus Extensive groups would have the highest relative weights and the weights for other RUG-III groups would decrease proportionally. The results of applying these methods to index calculation worked well and yielded hierarchically sound indexes for all of the groups; that is, the indexes for the highest groups in the hierarchy are higher than for those below it, and this pattern holds throughout the proposed new category. The nursing indexes in the new category, as well as in the existing rehabilitation category, are naturally more compressed (that is, encompass a smaller range) than those in the 44- group RUG-III rehabilitation groups. The groups within the new Rehabilitation plus Extensive category are more homogeneous than were the rehabilitation groups of the 44-group system. By removing the most clinically complex cases and better accounting for them by putting them in rehabilitation groups of their own, both the resulting proposed new category and the remaining rehabilitation category groups would be more homogeneous and, therefore, the relative weights for each set of groups would exhibit less variance.

**Comments:**

We would like an explanation as to why some of the current rehabilitation categories will experience a decrease in rate. Not all patients who were in those categories will be re-categorized into the new groups, therefore, we will experience a decrease in reimbursement for the same services being provided. Also, the proposed rate for the new category RVL, is LOWER than what we're currently reimbursed for RVB (the equivalent category). In other words, providers will be reimbursed even less, even if the residents qualify for the new RUG. Under any new proposed formula we don't understand how this would be less for a higher category of service. Since this is one of the more common RUG categories we would request that more detailed refinement of be done to help explain the rationale for this phenomena. We don't see how this works with the proposal that "the creation of a proposed new Rehab plus Extensive category would be a means of accounting more accurately for the costs of certain medically complex patients".

**Topic: (p. 29077/29078)**

Next, we simulated payments using the existing weights compared to the new weights to ensure that the refinement did not result in greater or lesser aggregate payments. The simulation results showed an almost exact match in payments under both case-mix models. However, the proposed new 53-group model did yield a slight decrease (less than 1 percent) in aggregate Medicare payments. To remove this minor variance, we then applied a factor of +.02 to calibrate the nursing indexes and re-ran the simulation. Using this calibration factor of +.02, we are able to ensure absolute parity of aggregate payment under the 53-group RUG-III system compared to the 44-group system.

**Comments:**

Although we have a number of concerns about the proposed rule, we are most concerned that the CMS estimate of the revenue neutrality on payments in the proposed rule is inaccurate. Our analysis shows that the proposed rule further reduces payment to SNFs in FY 2006 by about \$5.75 per patient day compared to what they were in FY 2005. This translates to a payment shortfall of an estimated \$400,000 in FY 2006 for our company. We strongly urge CMS to review its calculations and to make any necessary adjustments to correct for the inaccuracy.

Also a part of the revenue neutrality impact of the proposed rule is also predicated on the assumption that CMS will not modify the underlying basis of the SNF PPS, - the use and interpretation of the Minimum Data Set (MDS) in the SNF PPS. The look-back on the MDS into the previous hospital stay allows a facility to important information that allows SNFs to analyze the resident's condition and adequately plan for the appropriate level of care. We estimate that if these steps were taken that an additional \$10-\$12 reduction in the Medicare rates would occur. Elimination of the look-back will impede a nursing facility's ability to develop an appropriate care plan for the resident and penalize facilities that must commit substantial resources within the first few days after admission when patients are most unstable and resource intensive state and require a significant level of skilled nursing care for monitoring and treatment of symptoms related to their stay in the hospital.

The look-back provision was not established to determine that a particular service was delivered but rather to reflect that the types of patients that entered the SNF required more intensive care. Without the look-back provision the SNF will still provide the same level of care, but will not be able to be adequately compensated for that level of ongoing care until the 14-day assessment is undertaken.

**Proposed Refinements to the Case-Mix Classification System – 29078-29081****Topic: (p. 29079)**

As further explained in section II.B.4 of this proposed rule, these additional payments would partially offset the expiration of the temporary add-on payments that will occur, under the terms of section 101(c) of the BBRA, upon the implementation of this proposed case-mix refinement. We believe that implementing the proposed case-mix refinement in this manner will carry out Congressional intent that the BBRA's temporary payment add-ons should not continue indefinitely into the future, while at the same time ensuring that payments under the SNF PPS continue to support the quality of care furnished in this setting.

**Topic: (p. 29080)**

We understand that the expiration of the temporary payment increases, provided for in that legislation, results in a significant reduction in Medicare's payments between FY 2005 and FY 2006. In fact, MedPAC has consistently urged that, until CMS can design a new payment methodology, some or all of the temporary add-on payments be retained and allocated towards beneficiaries with complex medical needs. While this proposed rule sets forth refinements to the existing case-mix classification system and RUG-III categories, we are soliciting comments on the economic impact of the resulting payment changes, as well as their potential impact on beneficiaries' access to quality SNF care. We also invite comments on possible ways in which the case-mix classification system itself might be further modified to help mitigate the effect of the payment changes.

**Comment:**

We completely disagree at this time with the assertion that the temporary add on rates should not be continued. While we support a program to enhance the quality of our residents through a thorough and well designed program modifications, we do not feel that there has been enough consideration taken into account to support this position at this time. We would recommend that all the studies that are currently being done and that are due through the end of this year be completed so that a complete plan be designed and shared with both beneficiary and provider communities.

We are also concerned about the impact of the proposed rule on the financial stability of the long-term care sector, particularly as it relates to nursing homes. By holding aggregate SNF payments in FY 2006 at the same level as in FY 2005, the proposed rule cuts approximately \$510 million from what aggregate SNF payments would have been in FY 2006 without the refinement – i.e. an amount equivalent to the 3 percent market basket update. We are concerned that the implementation of the proposed rule as currently designed will have an undesirable destabilizing effect for numerous providers when the refinement is introduced in the second quarter of FY 2006. As an alternative, we support the proposal by AHCA that recommends that CMS develop an alternative implementation approach that would smooth out or stabilize rates by eliminating the Medicare rate cliff during FY 2006 and thereby help ensure the consistency of SNF payments.

**Topic: (p. 29079/29080)**

One way to accomplish this could be by ensuring that the MDS data used in making such classifications reflect only those services that are actually furnished during the SNF stay itself rather than during the preadmission period (for example during the prior qualifying hospital stay). In the July 30, 1999 SNF PPS final rule (64 FR 41668 through 41669), we noted a public comment that questioned the appropriateness of the MDS's 14-day "look-back" provision in the specific context of the SNF level of care presumption. While we made no revisions to the look-back provision at that time, we specifically reserved the right to reconsider the continued use of this mechanism in the future. Subsequent analysis in this area has focused on the four items contained in the Special Service section of the MDS (P1a—IV medications, suctioning, tracheostomy care, and use of a ventilator/respirator) that serve to classify residents into Extensive Care, the category used for the most medically complex SNF patients under the RUG— III classification system. This analysis indicates that the use of the look-back provision has caused a significant number of residents to classify to the Extensive Services category based solely on services (such as intravenous medications) that were furnished exclusively during the period before SNF admission.

**Comments:**

We understand the reasoning for recording accurate use of services, however, the rationale is driven by reimbursement, and the MDS drives resident assessment, care planning, and quality of care. The look-back period allows the assessor to document all relevant information to adequately complete a plan of care that identifies risks and strengths for each resident. In regards to services, even though a service may have been discontinued prior to admission, there is still a need for ongoing monitoring and assessment. Removing the look-back period would prevent facilities from capturing this higher level of care, as many residents would be placed in lower categories, even though the same amount of resources are being utilized. In turn, facilities would not be adequately reimbursed for those services and the impact would negate the purpose of the 9 new categories. For example, if an IV medication is discontinued prior to admission, there is still a need for ongoing monitoring for recurring symptoms, infection, and possible need to reinstate the treatment. It is also likely that the resident would still be receiving another form of antibiotic, and the acute illness may still be present.

We recommend that CMS not eliminate the look-back period, given the negative impact it would have on quality of assessment and the plan of care.

If the look-back period is removed, we urge you to research alternatives to capture the most medically complex residents. One way this might be accomplished is to revise the requirements for Extensive Service to include other MDS items, and/or combination of items to identify those residents requiring extensive services for an acute condition, many of whom have received IV medications during the hospital stay. For example, item P1e, Monitoring acute medical condition could be combined with items from Section I, Diagnoses, to identify those residents requiring acute monitoring for conditions such as CHF, Hip fracture, Antibiotic resistant infection, pneumonia and other acute infections. This may allow facilities to continue to capture those residents at the highest level of care, as well as better align payments with services that are being provided post-admission. We urge you to research alternatives prior to eliminating the look-back period.

**Topic: (p. 29080)**

We anticipate that this change can be accomplished through an update to the MDS Manual instructions, and will not involve system changes at the facility, State agency, or Federal level.

**Comments:**

In Medicaid Case-Mix states, such as Washington, we do anticipate that such changes would not only create system changes at the facility and State agency levels, but more importantly the proposed refinements will increasingly place our company at greater financial risk.

**Topic: (p. 29080)**

..we have received recommendations to decrease or eliminate the grace day period specifically for the 5-day PPS MDS assessment. We invite comments on this specific recommendation as well as decreasing or eliminating the grace periods associated with all PPS MDS assessments. Another example of a possible policy change on which we invite comment would be whether it might be appropriate to eliminate the projection of anticipated therapy services during the 5-day PPS assessment.

**Comment:**

In the best interest of our residents, and in order to continue to provide quality care, the elimination of projection of anticipated therapy would be detrimental in our efforts to achieve our goal and still receive adequate reimbursement for services provided. There are many instances in which it is in the best interest of the resident to first address other clinical issues (hydration, pain, infection) prior to initiating the full course of therapy. Eliminating the projected therapy minutes would create an incentive for facilities to start ordered therapy immediately, and perhaps not allow the resident adequate time to address other acute conditions. The other possibility is that therapy may be delayed until the observation period for the next assessment, since there would be no reimbursement for therapy services provided. The projected therapy allows the facility and the resident to choose a course of treatment that will provide the resident ample opportunity to succeed, yet provides reimbursement for the services provided during the first 14 days. We feel strongly that if this is eliminated, quality of care is at risk.

Grace days, especially on the 5 day assessments, are important in capturing an accurate level of care for the same reasons mentioned above. At times a resident may refuse therapy, or therapy may be placed on hold, due to other clinical issues or the need for the resident to adjust to their new environment. Grace days can also be utilized when a resident arrives to the facility late in the day. Removing grace days would make it impossible, in some cases, for facilities to receive adequate reimbursement for the care being delivered while keeping the needs of the resident the ultimate priority.

**Topic (p. 29081)**

We also want to encourage incremental changes that will help us build toward these longer-term objectives. For example, several automated medical record tools are now available that could allow hospitals and SNFs to coordinate discharge planning procedures more closely. These tools can be used to ensure communication of a standardized data set that can also be used to establish a comprehensive SNF care plan. Improved communications may reduce the incidence of potentially avoidable re-hospitalizations and other negative effects on quality of care that occur when patients are transferred to SNFs without a full understanding of their care needs. CMS is looking at ways that Medicare providers can use these tools to generate timely data to support continuity across settings. We are also interested in comments on payment reforms that could promote and reward such continuity, and avoid the medical complications and additional costs associated with re-hospitalization. Some of the ideas discussed here may exceed CMS's current statutory authority. However, we believe that it is useful to encourage discussion of a broad range of ideas for debate of the relative advantages and disadvantages of the various policies affecting this important component of the health care sector, to ensure that our administrative actions provide maximum support for further steps toward higher quality postacute care. We welcome comments on these and other approaches.

**Comment:**

Our organization is supportive of the goal to move toward an electronic health record and improve communications amongst providers. Continuing our efforts to promote and facilitate continuity of care will result in improved quality for our residents. It is important to note that the lack of resources and current level of technology and equipment to support our efforts is our largest barrier. We urge you to consider offering financial incentives to those who participate in these efforts.

We also support Medicare payment and delivery system adjustments that ensure the most appropriate placement for Medicare beneficiaries needing post-acute care. Such system improvements may include implementing a uniform patient assessment instrument for post-acute care settings and ensuring that financial incentives result in the best clinical post-acute placement for the patient. Such an integrated payment system must be patient-centric, i.e., based solidly on patient characteristics and outcomes, and be based on a common patient-centered quality assessment system. We feel with the wide spectrum of specialty areas, and differences in reimbursement systems, that an enormous amount of research should be completed involving experts from all areas of healthcare.

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**Implementation Issues – 29081**

**Topic: (p. 29081)**

We note that the resulting reduction in payment will be partially offset by the increase in the RUG case-mix indexes, as explained previously in section II.B.3 of this proposed rule. We invite comments on all aspects of implementing the proposed case-mix refinements, including our plan to defer implementation until January 1, 2006.

**Comments:**

In order to provide consistency amongst software vendors, as well as maintain the January 1, 2006 implementation date, please consider providing vendors with a similar .dll file as was provided when the 44 group RUGS were implemented.

Please provide instructions regarding the cross-over period.

**Questions:**

- If a resident has a PPS assessment completed in December, that would normally cover payment into January, does payment continue based on the 44 RUGS until the next assessment is completed?
- If errors are found on assessments, after the transition period, and an assessment prior to January 1, 2006 needs to be corrected, how will facilities calculate based on the 44 RUGS after the 53 RUGS have been implemented?

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**Assessment Timeframes – 29082**

**Topic: (p. 29082)**

We would like to take this opportunity to clarify existing requirements regarding completion of Other Medicare Required Assessments (OMRAs) for beneficiaries reimbursed under the SNF PPS. An OMRA is due 8 to 10 days after the cessation of all therapy (occupational and physical therapies and speech-language pathology services) in all situations where the beneficiary was assigned a rehabilitation RUG-III group on the previous assessment.

**Comment:**

Please clarify the term “due” underlined above. Please clarify if you are referring to the Assessment Reference Date (A3a) or when the assessment must be completed by (R2b).

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**SNF Certifications and Recertifications Performed by Nurse Practitioners and Clinical Nurse Specialists – 29082**

**Topic: (p. 29082)**

Following the enactment of this legislation, we received numerous inquiries asking us to define “direct” and “indirect” employment relationships in greater detail. In the July 26, 1995 final rule (60 FR 38268), we stated that factors indicating whether a NP or CNS has a direct or indirect employment relationship include, but are not limited to the following:

- The facility or someone on its medical staff has the authority to hire or fire the nurse;
- The facility or someone on its medical staff furnishes the equipment or place to work, sets the hours, and pays the nurse by the hour, week, or month;
- The facility or someone on its medical staff restricts the nurse’s ability to work for someone else or provides training and requires the nurse to follow instructions.

**Comment:**

In regards to the comment “someone on it’s medical staff has the authority to hire or fire the nurse”. Would this apply to a NP or CNS who works under the Medical Director, who is under a contract with the SNF? Please provide clarification.

In regards to the comment “furnishes the equipment of place to work”. Would this apply to an office space at the facility that the NP or CNS utilizes for weekly visits to the facility? Please provide clarification.

**Concurrent Therapy – 29082**

We invite comment on the most effective way to prevent the abuse of this practice, and to ensure that concurrent therapy is performed only in those instances where it is clinically justified.

**Comment:**

As the proposed rule notes, and we agree, there are circumstances where concurrent therapy is clinically appropriate and therefore proper as a covered service, and instances where it is not. We also believe that it is inappropriate for any entity to coerce a therapist into conducting concurrent therapy that is inconsistent with the therapist’s sound clinical judgment. Conversely, concurrent therapy, administered responsibly can not only meet the complex skill level required for Medicare coverage, but also can benefit the individual patient.

Medicare has systems in place to ensure that concurrent therapy meets the skill level and is clinically appropriate for the given beneficiary. First, therapists are already required to document the level of complexity and sophistication of the services that they provide to a given beneficiary. Second, focused medical reviews by the FIs are effective in detecting and deterring the improper use of concurrent therapy. There is nothing to indicate to the contrary. Moreover, Medicare’s current enforcement system is further enhanced by state laws and professional codes of ethics. Specifically, the American Physical Therapy Association and the laws in many states set out a code of ethics for physical therapists and standards of practice, respectively. We believe that vigorous enforcement of these state and professional codes, along with Medicare’s current guidance, should deter the inappropriate use of concurrent therapy.

**Topic: Tables 4, 4a, 5, 5a Case-Mix Adjusted Federal Rates and Associated Indexes (p. 29083-29086)**

**Topic: Tables 6, 6a, 7, 7a Case-Mix Adjusted Federal Rates by Labor and Non-Labor Component (p. 29086-29090)**

We believe and would urge CMS to develop a SNF based wage index. The current hospital based system we feel does not appropriate address the employees and providers fairly as a whole. We have an example of how the wage scale currently does not work as the scale in our area just south of Seattle Washington has dramatically dropped over the course of the last 4 years while the wage scale in the nearby markets north have increased. The geography of the Puget Sound region shows that employers share their employees across these urban county lines and to have such drastically different pay scales for SNF facilities does not relate to the reality of the situation. We urge CMS to develop a SNF specific wage index that would allow the payment system to more accurately reflect differences in area wage levels and would allow SNF's to request reclassification to alternate, more appropriate local market designations.

**Topic: Qualifying Three-Day Inpatient Hospital Stay Requirement (p. 29098-29100)**

More recently, it has been suggested that because of changes in hospital admission practices that have occurred since the Congress enacted this provision in 1965, some patients who at that time would have been a hospital inpatient for at least 3 days are instead now placed in observation status initially, before being formally admitted as a hospital inpatient.

These inquiries assert that in such situations, the care furnished during observation may be indistinguishable from the inpatient care that follows the formal admission, so that the beneficiaries themselves often learn of the difference only after they were transferred to the SNF and failed to meet the SNF benefit's prior hospital stay requirement. The inquirers argue that it is unfair to deny SNF coverage to such a beneficiary based solely on what they characterize as a mere recordkeeping convention on the part of the hospital rather than a substantive change in the actual care that the beneficiary receives there.

... with regard to those beneficiaries whose formal admission to the hospital as an inpatient is immediately preceded by time spent in hospital observation status, we invite comments on whether we should consider the possibility of counting the time spent in observation status toward meeting the SNF benefit's qualifying 3- day hospital stay requirement.

**Comment:**

We feel very strongly that this issue has negatively impacted the resident's access to care and services that they are entitled to under Medicare. Our recommendation is that all days spent in the hospital prior to the acute care stay count toward the qualifying hospital stay, including the emergency room and observation unit. The services the resident receives once their care at the hospital begins, should be the same throughout the course of care, regardless of the location within the hospital. The fact that their encounter results in an inpatient stay is sufficient in determining the need for continued skilled care.

It has also been difficult to receive accurate information from the hospital related to the status of the resident at various times from the emergency room through discharge. Often the information or dates of service that we receive is limited and does not specify whether or not the resident was in an observation status. We urge you to look at ways in which this information can be more readily shared amongst providers. There is also a lack of understanding with the discharge planners on the requirements for Medicare in the SNF, which has subsequently resulted in denied coverage.

One way this issue could be resolved would be to rely on the physician certification. If a physician certifies a need for skilled care, regardless of the length of time spent in the hospital, the beneficiary should be entitled to SNF coverage.

CMS should exercise its authority to eliminate the requirement of a 3 day hospital stay for SNF coverage and we thank you for reviewing these concerns.

## **Closing Comments**

First, we would like to thank CMS for the opportunity to allow us to share our comments concerning the proposed changes to the PPS system.

Currently CMS is trying to resolve the problem of the Medicare PPS payment system. While we support the objectives to set up the system to be fair and responsible to the residents who we care for, we can not support action that just deals with the problems of Medicare reimbursement. Currently the Medicaid system in this country is broken and no one seems to want to take charge and address it. States are allowed to woefully underpay for the services that their clients need and CMS allows this to continue through the approval of the Medicaid programs. We must address the underfunding in the Medicaid system at the same time as we address concerns of the Medicare RUG's refinement. The national average for margins in the Skilled Nursing community is 2.8% and under the current proposal that will only shrink the margins even further. The last time this type of change occurred many SNF companies were forced into bankruptcy and closures.

CMS must also address the proposed changes to the Medicare bad debt system. Currently several states including the state of Washington are allowed to not pick up their share of the co payments for their Medicare residents. Why is it deemed acceptable that the provider should have to pay for this? If the proposed changes in the bad debt system are allowed to stay in place then CMS and the legislature must change the rulings that the state not pick up its responsibility. It is estimated that the proposal will cost the Medicare providers over \$90 million in fiscal year 2006 and that coupled with estimates of the Medicare cliff of \$75 million are not acceptable.

*KEY POINTS:*

*Implementation of the proposed refinement of the case-mix classification system, if implemented in its entirety, will NOT better account for medically complex patients.*

*Based on our data and research, the CMS estimate of the revenue neutrality on payments in the proposed rule is inaccurate.*

*Providers have NOT completely adjusted to SNF PPS, and results of recent edits raise greater concern that rates have NOT covered the total cost of care to beneficiaries.*

*Stratification for the lowest level ADL scores IS warranted for ADL scores lower than 7.*

*Our own simulations, based on data provided by CMS, does NOT show a match in payments under both case-mix models.*

*Temporary add-ons SHOULD continue until further research is completed and a refined case mix classification system will better account for medically complex patients.*

*The look-back period should NOT be removed due to the negative impact on assessment and care planning.*

*The use of grace days should NOT be removed, especially in relation to the 5 day PPS assessment.*

*A SNF specific wage index should be developed to more accurately reflect differences in area wage levels and allow SNF's to request reclassification to alternate, more appropriate local market designations.*

*Considering all of the proposed changes to MDS coding, your presumption that "the groups in this new category would encompass care that is at least as intensive as that identified by any of the upper 26 RUG-III groups under the original, 44-group RUG-II classification system", is incorrect.*

*Your anticipation that "this change can be accomplished through an update to the MDS Manual instructions, and will not involve system changes at the facility, State agency, or Federal level" is incorrect in relation to Medicaid case-mix states, such as Washington.*

*CMS should assist nursing facilities to upgrade and improve their information technology infrastructure by providing funding and technical assistance in order for SNF's to participate in future efforts toward an integrated health delivery system.*

*Time spent in hospital observation status SHOULD count toward meeting the 3 day hospital stay requirement.*

In conclusion, we believe that the proposals could be significantly improved. While we wish to support the concept of RUG refinements, we cannot do so without the whole picture being observed with both Medicare and Medicaid funding for our residents. We wish to work with the agency and provider community to achieve a workable framework for the removal of the add-ons without the elimination of the funding represented by the add-ons. We look forward to continuing to work with CMS in our mutual effort to provide the best possible care for America's frail elderly.