

Submitter : Mr. Patrick Cucinelli
Organization : NYAHS
Category : Health Care Professional or Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

July 12, 2005

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

Via e-mail: <http://www.cms.hhs.gov/regulations/ecomments>

Re: Comments on CMS-1282-P Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) for FY 2006

Dear Sir or Madam:

Please accept for consideration these comments regarding the above referenced proposed rule.

These comments are made on behalf of the membership of the New York Association of Homes and Services for the Aging (NYAHS), which is the New York state affiliate of the American Association of Homes and Services for the Aging (AAHSA). Founded in 1961, NYAHS is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including nursing homes, senior housing, adult care facilities, continuing care retirement communities, assisted living and community service providers. NYAHS's more than 650 members serve an estimated 500,000 New Yorkers of all ages annually.

Issue

Wage Index Data

As you are aware, CMS has been charged by Congress to develop a SNF-specific wage index based on wage data collected from SNF cost reports. CMS did develop a prototype SNF index using 1998 and 1999 cost report data, but has not proposed such an index for implementation due to concerns about the reliability of the data. NYAHS has since worked with CMS on the development of cost report edits to address this concern. We respectfully urge CMS to continue to work towards developing and implementing a SNF wage index. In the meantime, this proposed expansion of the NYC MSA should not be permitted to further reduce Medicare payments to SNFs in the area.

As detailed above, CMS is deferring the issue of implementing an SNF-specific wage index, which was supposed to be developed pursuant to the Balanced Budget Act of 1997 as part of the implementation of PPS. Since a SNF wage index has never been implemented by CMS, SNF PPS rates continue to be calculated based upon the hospital wage index. NYAHS has estimated that the implementation of such an index would have a significant positive impact on New York SNF PPS rates and continues to advocate for this change. NYAHS has had lengthy discussions with CMS on this issue and contends that all the necessary pieces are in place to finally act upon this mandate. There are other areas of New York that will also be negatively impacted by reductions in hospital-based wage indices. NYAHS's analysis shows that moving to an SNF wage index would mitigate some of the negative impact of the proposed geographic reclassification on New York providers.

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

Direct Versus Indirect Employment Status of NPs

The proposed rule also offers clarification on the concept of indirect employment status of nurse practitioners (NPs), specifically regarding their ability to complete certifications and re-certifications. While NYAHS does not oppose this provision per se, there is some concern raised by the language used. In New York, many nursing homes have adopted a model of care based on the use of employed nurse practitioners. Studies have indicated that this model produces significant positive results in terms of clinical outcomes, survey results, and cost savings to the system.

There is language in the Social Security Act that seems to be concerned with the notion that the employed NP is somehow more susceptible to a conflict of interest between scope of practice and SNF employment than an NP working under contract in the SNF. While not commenting on the historical basis for this language, NYAHS believes that such references are now wholly inappropriate and counter-productive towards encouraging a model of care that has produced outstanding positive results. There does not exist at this time any valid reason for singling out the employed NP as compared to the contractual NP, and this proposal only perpetuates a grossly unfair stereotype.

NYAHS strongly recommends that this language be rejected and that references to the arbitrary and unfounded distinction between the employed and contractual NP be eliminated in this proposed rule.

Case-Mix Adjustment and Other Clinical Issues

Along the same theme as the AAHSA Quality First Initiative, CMS is looking for comments from providers on incorporating some pay for performance standards in the Medicare rate. Obviously, this remains a difficult concept to put into practice. There are no specific provisions being proposed for FY2006, but CMS is looking for ideas on ways to implement what they are calling provider-centric prospective payment methodologies. CMS views the expansion of standardized electronic health records as a key element in being able to move in this direction. NYAHSAs support the general concept of pay for performance as long as the following criteria are met:

1. The measures used are objective and are not geared towards favoring providers who serve one class of patient over another;
2. The measures should not penalize providers who take on a more difficult patient population that may statistically produce less favorable clinical outcomes;
3. Pay for performance should be geared towards incentives to enhance quality over and above the standard Medicare reimbursement rate, and should not be used to penalize providers by reducing rates;
4. CMS should avoid using or incorporating survey data, which NYAHSAs believe may be subjective and variable between geographic regions and various state survey agencies;
5. The measures must be consistent between regions of the country; and
6. The measuring tool should ensure consistency between providers and evaluators.

Conclusion

While NYAHSAs generally support the concept of pay for performance, we strongly urge that the process be carefully considered with extensive input from all stakeholders. Any system that is implemented must be based upon objective and meaningful measures.

Implementation Issues

In October of 2002, additional rate add-ons were also eliminated in what was known colloquially as the Medicare Cliff. With no offsetting measures implemented, the 2002 elimination had a devastating impact on New York skilled nursing facilities (SNFs), which suffered on average a 10 percent reduction in their Medicare reimbursement. Therefore, we are deeply concerned by our estimate indicating that the elimination of the add-ons will result in an average 10 percent decrease in Medicare rates. NYAHSAs has calculated that New York nursing homes stand to lose approximately \$125 million in Medicare revenue. NYAHSAs is concerned that only half of the revenue loss from the add-on elimination is being offset by the actual RUG refinements. The rule proposes total funding for the adjustment for non-therapy ancillaries of the equivalent of 3 percent of aggregate expenditures under the SNF prospective payment system (PPS). Inexplicably, this funding level was predicated on the outlier pool for inpatient rehabilitation facilities (IRFs). NYAHSAs seriously questions the adequacy of this 3 percent standard given the longer average lengths of stay in SNFs than in IRFs, greater heterogeneity in the SNF population versus the IRF population, the broader variety of services included in the SNF PPS, and the high degree of variability in outlier costs in the SNF setting. Furthermore, it was the intent of Congress that the temporary add-ons should be a corrective measure put in place pending the RUG III refinement. Assuming that the temporary add-ons fulfilled this purpose, to implement a system refinement that falls short by 50 percent is further extending the original problem. While on a nationwide, statistical basis the refinements may equal out to covering 50 percent of the loss, for individual providers with varying complements of RUG scores among patients, there is the possibility that many providers will not even make up 50 percent of their loss resulting from the rate add-on elimination. Indications from our membership show that those facilities that have focused on the higher scoring rehabilitation patients are those most likely to fall short. All facilities benefited equitably from the add-ons, while the refinements will impact facilities differently, based upon the mix of patients. The current proposal will negatively impact those facilities that focused on higher scoring rehabilitation patients and possibly create an access problem for these residents. This would occur at the same time that enforcement of the 75 percent rule is creating problems for inpatient rehabilitation facilities in New York. While on average only 50 percent of the funding lost through elimination of the rate add-ons is actually being compensated for by the RUG refinement, the other half is being offset by counting the MBI adjustment for federal fiscal year (FY) 2006 as replacement funding. NYAHSAs believes that this is disingenuous and grossly unfair to facilities. In essence, the statutorily required inflationary adjustment for FY2006 is being used to fund the short fall created by the inadequacy of the RUGs refinement proposal. Viewed from this perspective, it is clear that facilities are suffering a genuine loss from the elimination of the rate add-ons. It should also be noted that since MBI adjustments have a compounding impact over time, the effect of under-funding the refinements will worsen over time and be far greater than a one-year loss. NYAHSAs recommends that the current RUGs refinement be viewed as only a partial offset to the temporary add-ons. Therefore, only 50 percent of the add-ons should be eliminated at this point, pending a refinement that fully compensates for the loss of the add-ons. Furthermore, nursing homes should be entitled to receive their full, unencumbered MBI adjustment as mandated under the current rate methodology.

Case-Mix Adjustment and Other Clinical Issues

CMS is proposing significant changes to rules governing patient assessment, classification and eligibility. The most significant Minimum Data Set (MDS) change being proposed is the elimination of the hospital look-back period for the initial 5-day assessment. In essence, CMS is proposing that care delivered in the hospital just prior to transfer to the SNF should not impact the SNF's Medicare payments. CMS obviously sees the potential for significant cost savings with this change. Specifically, IV medications, suctioning, tracheostomy care, and ventilator/respirator services provided in the hospital would no longer be counted on the 5-day MDS assessment. NYAHSAs is opposed to this measure on the basis of the potential negative impact on patient care. Part of the original justification for the hospital look-back was to help ensure consistency between the care provided in the hospital and the continuation of that care in the sub-acute setting. To the extent that the system was designed to promote this consistency, both the MDS assessment process and the resulting reimbursement recognized the need for the hospital look-back. This elimination would help to foster a disconnect between the acute and sub-acute levels of care, that would be detrimental to patient care. The SNF PPS has consistently viewed the nursing home sub-acute stay as an extension of the hospital stay. This current proposal looks to reverse that philosophy. Also, regarding the 5-day assessment, CMS is proposing eliminating any grace days and also eliminating the projection for anticipated therapy. Both these changes, while surely creating a cost savings, again promote a discontinuity in patient care and fail to recognize the full cost of the patient's sub-acute care. Eliminating anticipated therapy will also compound the negative financial impact of the proposed elimination of the 6.7 percent add-on to the RUG-III therapy categories discussed earlier. While not being proposed for FY2006, CMS is soliciting comments on the prospect of changing the three-day hospital qualifying stay

to include observation days. In seeking input on this idea, CMS is acknowledging the fact that hospital admission practices have changed and that hospitals are utilizing more observation days. Many times these observation days are indistinguishable from regular inpatient days. For this reason, NYAHSAs would support a proposal in this area as consistent with changing standards of practice. Having said that, there seems to be an inconsistency between this idea which promotes continuity of care and the proposed elimination of the hospital look-back period for the initial 5-day assessment, which does not. With more states now using the MDS and RUG-III classification system as the basis for determining Medicaid case mix adjusted reimbursement, NYAHSAs recommends that the further refinement be made to the RUGs categories to more fully capture the resource utilization of patients with behavioral and cognitive impairments. While the MDS has always been an excellent tool for capturing therapy intensive services, it is generally recognized that those services related to behavioral/cognitive issues have not been adequately captured and reflected in RUG-III case mix indices. To this end, we support efforts to conduct time studies to update the predicted hours for each RUG-III category. The proposed changes to the MDS seemed to be driven by cost considerations with no quality of care dimension. In fact, NYAHSAs believes that these measures could have a negative impact on quality of care, by creating a discontinuity in patient care between the acute and sub-acute settings, and by failing to fully recognize the full costs of care for the sub-acute patient. In addition, continued refinement of the RUG-III system is still needed in order to capture behavioral/cognitive resource utilization across the full spectrum of RUGs categories.

Proposed Revisions to the SNF PPS Labor Market Areas

Based upon recommendations from the Office of Management and Budget (OMB), CMS is proposing an extensive geographic reclassification. This reclassification has already impacted downstate hospitals in New York that suffered a serious loss of revenue last year when the New York City metropolitan statistical area (MSA) was changed to include three northern New Jersey counties. The net impact of this expansion was to lower hospital Medicare payments for New York providers while raising payments to those providers in the affected area of New Jersey for FY 2005. The impacted areas in New York include: the Bronx, Kings, New York, Putnam, Queens, Richmond, Rockland, and Westchester counties. The proposed rule would make the geographic reclassification applicable to the methodology for calculating SNF PPS rates as well. CMS is proposing implementing this change without any hold harmless or transition provisions. They acknowledge that there will be winners and losers in the process, but state that overall the transition would be budget neutral on a system-wide basis. NYAHSAs's concerns in this area focus mainly on the impact on SNFs in the New York City region, where the re-classification essentially results in transfer of Medicare funding from New York to New Jersey with no sound public policy basis for doing so. A careful analysis shows that wages in the three New Jersey counties that would be included in the expansion (Bergen, Hudson, and Passaic) are not competitive with New York City, and that employers are dealing with distinct labor markets. The proposed change would result in reduced payments to providers located in New York City, while increasing payments to these three counties. To a large degree, labor costs in the NYC MSA are driven by collective bargaining agreements. Organized labor will certainly not reduce their wage demands as a result of this MSA reclassification, nor is the cost of labor for New York City providers going to decrease. From this perspective, the shifting of resources from New York City to northern New Jersey appears arbitrary and lacking in any sound public policy basis. The competition for staff in New York is intense, with labor shortages impacting most providers. This is only going to worsen the labor situation, possibly drawing resources away from New York City (with its higher cost of living) towards the New Jersey suburbs. The hourly wages of SNF workers bear out the sharp distinctions between the New York City and Northern New Jersey labor markets. Based on 1999 Medicare SNF cost report data, the average reported hourly salary was \$14.10 in the Bergen-Passaic MSA and \$11.68 in the Jersey City MSA (which includes Hudson County) versus \$17.78 in the NYC MSA, for differences of 26 percent and 52 percent, respectively. Part of the rationale for the expansion of the NYC MSA change is based on certain assumptions regarding changes in worker commuting patterns. Therefore, there is no sound demographic basis for making this change at this time. It should also be kept in mind that the majority of workers in post acute care settings are paraprofessionals (i.e., aides, housekeepers, dietary, laundry and maintenance workers, etc.). In general these workers tend to find employment in a facility or agency relatively close to home, and are less likely than professional and technical employees to incur the expense of lengthy commutes. General assumptions regarding commuting patterns simply do not apply to the majority of the SNF and HHA workforce. This illustrates inherent problems with both the proposed change in the MSA, and the continued use of the hospital wage index for SNF and HHA services.

CMS-1282-P-76-Attach-1.WPD



Attachment #76

150 State Street, Suite 301 Albany, New York 12207-1698 Telephone (518) 449-2707 Fax (518) 455-8908 Web www.nyahsa.org

July 12, 2005

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

Via e-mail: <http://www.cms.hhs.gov/regulations/ecomments>

Re: Comments on **CMS-1282-P Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNF) for FY 2006**

Dear Sir or Madam:

Please accept for consideration these comments regarding the above referenced proposed rule.

These comments are made on behalf of the membership of the New York Association of Homes and Services for the Aging (NYAHSA), which is the New York state affiliate of the American Association of Homes and Services for the Aging (AAHSA). Founded in 1961, NYAHSA is the only statewide organization representing the entire continuum of not-for-profit, mission-driven and public continuing care, including nursing homes, senior housing, adult care facilities, continuing care retirement communities, assisted living and community service providers. NYAHSA's more than 650 members serve an estimated 500,000 New Yorkers of all ages annually.

Elimination of Rate Add-ons and RUGs Refinement

NYAHSA recognizes that the current 6.7 and 20 percent rate add-ons were implemented as temporary measures designed to address acknowledged inequities in the allocation of resources in the current resource utilization groups (RUG III). In general, it was determined that RUG III failed to fully recognize the resources needed to care for residents in certain categories. As an interim corrective measure, a 20 percent add-on was applied to RUG III extensive, special care and clinical categories: SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2 and CA1. In addition, a similar 6.7 percent add-on was applied to the rehab categories: RUC, RUB, RUA, RVC, RVB, RVA, RHC, RHB, RHA, RMC, RMB, RMA, RLB and RLA.

1. The proposal is not budget neutral and will likely have an overall negative impact on nursing home payment rates.

In October of 2002, additional rate add-ons were also eliminated in what was known colloquially as the *Medicare Cliff*. With no offsetting measures implemented, the 2002 elimination had a devastating impact on New York skilled nursing facilities (SNFs), which suffered on average a 10 percent reduction in their Medicare reimbursement. In New York, where nursing homes are under funded in the Medicaid rate by over 10 percent relative to actual costs, providers are still feeling the pain of the 2002 reduction.

In implementing the current add-on elimination, it is critical that CMS ensure that nursing homes do not suffer a further degradation of their Medicare reimbursement. Therefore, we are deeply concerned by our estimate indicating that the elimination of the add-ons will result in an average 10 percent decrease in Medicare rates. NYAHSAs has calculated that New York nursing homes stand to lose approximately \$125 million in Medicare revenue.

On a nationwide basis, CMS expects that the rate add-on elimination will result in a loss of \$1.02 billion to providers. CMS expects this loss to be offset by an increase of \$510 million from the RUG refinement and an additional \$510 from the Medicare Market Basket Index (MBI) increase. As detailed below, NYAHSAs contends that the numbers will not work out as neatly as this CMS formula indicates.

2. The proposal is inadequate to fully compensate nursing homes for the loss of the rate add-ons.

NYAHSAs is concerned that only half of the revenue loss from the add-on elimination is being offset by the actual RUG refinements. The rule proposes total funding for the adjustment for non-therapy ancillaries of the equivalent of 3 percent of aggregate expenditures under the SNF prospective payment system (PPS). Inexplicably, this funding level was predicated on the outlier pool for inpatient rehabilitation facilities (IRFs). NYAHSAs seriously questions the adequacy of this 3 percent standard given the longer average lengths of stay in SNFs than in IRFs, greater heterogeneity in the SNF population versus the IRF population, the broader variety of services included in the SNF PPS, and the high degree of variability in outlier costs in the SNF setting.

Furthermore, it was the intent of Congress that the temporary add-ons should be a corrective measure put in place pending the RUG III refinement. Assuming that the temporary add-ons fulfilled this purpose, to implement a system refinement that falls short by 50 percent is further extending the original problem. In order to be consistent with the intent of Congress, NYAHSAs contends that CMS should implement a system refinement that fully compensates for the loss of the temporary add-ons. By failing to do so, the proposed refinement is only correcting half the problem.

While on a nationwide, statistical basis the refinements may equal out to covering 50 percent of the loss, for individual providers with varying complements of RUG scores among patients, there is the possibility that many providers will not even make up 50 percent of their loss resulting from the rate add-on elimination. Indications from our

membership show that those facilities that have focused on the higher scoring rehabilitation patients are those most likely to fall short. All facilities benefited equitably from the add-ons, while the refinements will impact facilities differently, based upon the mix of patients. The current proposal will negatively impact those facilities that focused on higher scoring rehabilitation patients and possibly create an access problem for these residents. This would occur at the same time that enforcement of the *75 percent rule* is creating problems for inpatient rehabilitation facilities in New York.

3. Counting the MBI as partial compensation for the loss of the rate add-ons results in a genuine loss to providers.

While on average only 50 percent of the funding lost through elimination of the rate add-ons is actually being compensated for by the RUG refinement, the other half is being “offset” by counting the MBI adjustment for federal fiscal year (FY) 2006 as replacement funding. NYAHSa believes that this is disingenuous and grossly unfair to facilities. In essence, the statutorily required inflationary adjustment for FY2006 is being used to fund the short fall created by the inadequacy of the RUGs refinement proposal. Viewed from this perspective, it is clear that facilities are suffering a genuine loss from the elimination of the rate add-ons. It should also be noted that since MBI adjustments have a compounding impact over time, the effect of under-funding the refinements will worsen over time and be far greater than a one-year loss.

4. Conclusion

NYAHSa recommends that the current RUGs refinement be viewed as only a partial offset to the temporary add-ons. Therefore, only 50 percent of the add-ons should be eliminated at this point, pending a refinement that fully compensates for the loss of the add-ons. Furthermore, nursing homes should be entitled to receive their full, unencumbered MBI adjustment as mandated under the current rate methodology.

Geographic Reclassification

Based upon recommendations from the Office of Management and Budget (OMB), CMS is proposing an extensive geographic reclassification. This reclassification has already impacted downstate hospitals in New York that suffered a serious loss of revenue last year when the New York City metropolitan statistical area (MSA) was changed to include three northern New Jersey counties. The net impact of this expansion was to lower hospital Medicare payments for New York providers while raising payments to those providers in the affected area of New Jersey for FY 2005. The impacted areas in New York include: the Bronx, Kings, New York, Putnam, Queens, Richmond, Rockland, and Westchester counties.

The proposed rule would make the geographic reclassification applicable to the methodology for calculating SNF PPS rates as well. CMS is proposing implementing this change without any hold harmless or transition provisions. They acknowledge that there will be winners and losers in the process, but state that overall the transition would

be budget neutral on a system-wide basis. NYAHSAs' concerns in this area focus mainly on the impact on SNFs in the New York City region, where the re-classification essentially results in transfer of Medicare funding from New York to New Jersey with no sound public policy basis for doing so.

1. The proposed expansion is not supported by the economics of the region. The New York City wage area is clearly distinct from that of Northern New Jersey.

A careful analysis shows that wages in the three New Jersey counties that would be included in the expansion—Bergen, Hudson, and Passaic—are not competitive with New York City, and that employers are dealing with distinct labor markets. The proposed change would result in reduced payments to providers located in New York City, while increasing payments to these three counties. If, in fact, the employers in the New Jersey counties are competing with New York City providers for labor, then it certainly makes sense to raise payments in those areas, but not at the expense of the New York providers whose labor costs are not going to decrease in any event.

To a large degree, labor costs in the NYC MSA are driven by collective bargaining agreements. This is a heavily unionized area, much more so than the northern New Jersey counties. Organized labor will certainly not reduce their wage demands as a result of this MSA reclassification, nor is the cost of labor for New York City providers going to decrease. From this perspective, the shifting of resources from New York City to northern New Jersey appears arbitrary and lacking in any sound public policy basis. The competition for staff in New York is intense, with labor shortages impacting most providers. This is only going to worsen the labor situation, possibly drawing resources away from New York City—with its higher cost of living—towards the New Jersey suburbs.

Research by the Prospective Payment Assessment Commission (the predecessor to the Medicare Payment Assessment Commission) is instructive on this issue. It revealed that the current MSAs are often too large and characterized by an inner-city core labor market with higher wage costs than those in the surrounding areas.

The hourly wages of SNF workers bear out the sharp distinctions between the New York City and Northern New Jersey labor markets. Based on 1999 Medicare SNF cost report data, the average reported hourly salary was \$14.10 in the Bergen-Passaic MSA and \$11.68 in the Jersey City MSA (which includes Hudson County) versus \$17.78 in the NYC MSA, for differences of 26 percent and 52 percent, respectively.

2. There is little or no evidence that commuting patterns—a proffered justification for the MSA expansion—have changed.

Part of the rationale for the expansion of the NYC MSA change is based on certain assumptions regarding changes in worker commuting patterns. However, the U.S. Census Bureau's County-to-County Worker Flow Files demonstrate that there has not been any significant change or increase in the flow of workers between New York City

and northern New Jersey between the 1990 and 2000 census figures. Therefore, there is no sound demographic basis for making this change at this time.

It should also be kept in mind that the majority of workers in post acute care settings are paraprofessionals (i.e., aides, housekeepers, dietary, laundry and maintenance workers, etc.). In general these workers tend to find employment in a facility or agency relatively close to home, and are less likely than professional and technical employees to incur the expense of lengthy commutes. General assumptions regarding commuting patterns simply do not apply to the majority of the SNF and HHA workforce. This illustrates inherent problems with both the proposed change in the MSA, and the continued use of the hospital wage index for SNF and HHA services.

3. The proposal will have a significant adverse financial impact on SNFs located in the NYC metropolitan statistical area.

The 2002 elimination of certain Medicare SNF prospective payment system rate enhancements noted above had a major negative impact on providers and added to the current financial crisis. Obviously, a further reduction in Medicare payments will only serve to make a bad situation worse for SNFs in the NYC MSA.

NYAHSAs estimate that this change would reduce payments to SNFs in the affected MSA by an average of \$16.10 per day, totaling over \$27.8 million per year. SNFs in NYC experience lower private pay censuses than post-acute providers in other states. Arguably, this extensive reliance on Medicare and Medicaid funding makes the potential impact on these providers all the more significant and more difficult to offset.

4. The lack of a SNF-specific wage index only adds to the inequity of the MSA expansion.

For many years, NYAHSAs have been making the case that there are inherent inequities in the current system of using hospital wage data as the basis for determining Medicare Part A payments to SNFs. Providers in New York City and elsewhere in New York State are seriously disadvantaged by the continued use of the hospital wage index. At a time of continued labor shortages, the need to ensure that Medicare payments appropriately reflect current labor market dynamics is paramount. An SNF-specific wage index would more accurately reflect labor cost differentials between and among facilities.

As you are aware, CMS has been charged by Congress to develop a SNF-specific wage index based on wage data collected from SNF cost reports. CMS did develop a prototype SNF index using 1998 and 1999 cost report data, but has not proposed such an index for implementation due to concerns about the reliability of the data. NYAHSAs have since worked with CMS on the development of cost report edits to address this concern. We respectfully urge CMS to continue to work towards developing and implementing a SNF wage index. In the meantime, this proposed expansion of the NYC MSA should not be permitted to further reduce Medicare payments to SNFs in the area.

Conclusion

In summary, NYAHSAs reiterates its opposition to the proposed MSA reclassification with regard to the shifting of desperately needed Medicare funding from New York to New Jersey. We urge CMS to reject the proposed expansion of the NYC labor region.

SNF Wage Index

As detailed above, CMS is deferring the issue of implementing an SNF-specific wage index, which was supposed to be developed pursuant to the Balanced Budget Act of 1997 as part of the implementation of PPS. Since a SNF wage index has never been implemented by CMS, SNF PPS rates continue to be calculated based upon the hospital wage index. NYAHSAs has estimated that the implementation of such an index would have a significant positive impact on New York SNF PPS rates and continues to advocate for this change. NYAHSAs has had lengthy discussions with CMS on this issue and contends that all the necessary pieces are in place to finally act upon this mandate. There are other areas of New York that will also be negatively impacted by reductions in hospital-based wage indices. NYAHSAs's analysis shows that moving to an SNF wage index would mitigate some of the negative impact of the proposed geographic reclassification on New York providers.

Patient Assessment/Classification/Eligibility

CMS is proposing significant changes to rules governing patient assessment, classification and eligibility.

1. **Elimination of *hospital look-back* and other MDS changes are counter to standards of consistent patient care.**

The most significant Minimum Data Set (MDS) change being proposed is the elimination of the hospital look-back period for the initial 5-day assessment. In essence, CMS is proposing that care delivered in the hospital just prior to transfer to the SNF should not impact the SNF's Medicare payments. CMS obviously sees the potential for significant cost savings with this change. Specifically, IV medications, suctioning, tracheostomy care, and ventilator/respirator services provided in the hospital would no longer be counted on the 5-day MDS assessment.

NYAHSAs is opposed to this measure on the basis of the potential negative impact on patient care. Part of the original justification for the hospital look-back was to help ensure consistency between the care provided in the hospital and the continuation of that care in the sub-acute setting. To the extent that the system was designed to promote this consistency, both the MDS assessment process and the resulting reimbursement recognized the need for the hospital look-back. This elimination would help to foster a disconnect between the acute and sub-acute levels of care, that would be detrimental to patient care.

The SNF PPS has consistently viewed the nursing home sub-acute stay as an extension of the hospital stay. This current proposal looks to reverse that philosophy.

Also, regarding the 5-day assessment, CMS is proposing eliminating any grace days and also eliminating the projection for anticipated therapy. Both these changes, while surely creating a cost savings, again promote a discontinuity in patient care and fail to recognize the full cost of the patient's sub-acute care. Eliminating anticipated therapy will also compound the negative financial impact of the proposed elimination of the 6.7 percent add-on to the RUG-III therapy categories discussed earlier.

2. A change in 3-day hospital qualifying stay requirement is consistent with changing standards of practice.

While not being proposed for FY2006, CMS is soliciting comments on the prospect of changing the three-day hospital qualifying stay to include observation days. In seeking input on this idea, CMS is acknowledging the fact that hospital admission practices have changed and that hospitals are utilizing more observation days. Many times these observation days are indistinguishable from regular inpatient days. For this reason, NYAHSAs would support a proposal in this area as consistent with changing standards of practice. Having said that, there seems to be an inconsistency between this idea—which promotes continuity of care—and the proposed elimination of the hospital look-back period for the initial 5-day assessment, which does not.

3. Expansion to 53 RUGs categories enhances reimbursement at the sub-acute level, but does not address the needs of lower scoring patients.

NYAHSAs support the basic concept behind expanding the upper rehabilitation groupings to more fully recognize the care needs of those patients utilizing both extensive therapy and clinical services. With more states now using the MDS and RUG-III classification system as the basis for determining Medicaid case mix adjusted reimbursement, NYAHSAs recommends that the further refinement be made to the RUGs categories to more fully capture the resource utilization of patients with behavioral and cognitive impairments. While the MDS has always been an excellent tool for capturing therapy intensive services, it is generally recognized that those services related to behavioral/cognitive issues have not been adequately captured and reflected in RUG-III case mix indices. To this end, we support efforts to conduct time studies to update the predicted hours for each RUG-III category.

Conclusion

The proposed changes to the MDS seemed to be driven by cost considerations with no quality of care dimension. In fact, NYAHSAs believes that these measures could have a negative impact on quality of care, by creating a discontinuity in patient care between the acute and sub-acute settings, and by failing to fully recognize the full costs of care for the sub-acute patient. In addition, continued refinement of the RUG-III system is still

needed in order to capture behavioral/cognitive resource utilization across the full spectrum of RUGs categories.

Pay for Performance

Along the same theme as the AAHSA *Quality First Initiative*, CMS is looking for comments from providers on incorporating some pay for performance standards in the Medicare rate. Obviously, this remains a difficult concept to put into practice. There are no specific provisions being proposed for FY2006, but CMS is looking for ideas on ways to implement what they are calling *provider-centric prospective payment methodologies*. CMS views the expansion of standardized electronic health records as a key element in being able to move in this direction. NYAHSA supports the general concept of pay for performance as long as the following criteria are met:

1. The measures used are objective and are not geared towards favoring providers who serve one class of patient over another;
2. The measures should not penalize providers who take on a more difficult patient population that may statistically produce less favorable clinical outcomes;
3. Pay for performance should be geared towards incentives to enhance quality over and above the standard Medicare reimbursement rate, and should not be used to penalize providers by reducing rates;
4. CMS should avoid using or incorporating survey data, which NYAHSA believes may be subjective and variable between geographic regions and various state survey agencies;
5. The measures must be consistent between regions of the country; and
6. The measuring tool should ensure consistency between providers and evaluators.

Conclusion

While NYAHSA generally supports the concept of pay for performance, we strongly urge that the process be carefully considered with extensive input from all stakeholders. Any system that is implemented must be based upon objective and meaningful measures.

Direct Versus Indirect Employment Status of NPs

The proposed rule also offers clarification on the concept of indirect employment status of nurse practitioners (NPs), specifically regarding their ability to complete certifications and re-certifications. While NYAHSA does not oppose this provision *per se*, there is some concern raised by the language used. In New York, many nursing homes have adopted a model of care based the use of employed nurse practitioners. Studies have

indicated that this model produces significant positive results in terms of clinical outcomes, survey results, and cost savings to the system.

There is language in the Social Security Act that seems to be concerned with the notion that the employed NP is somehow more susceptible to a conflict of interest between scope of practice and SNF employment than an NP working under contract in the SNF. While not commenting on the historical basis for this language, NYAHSAs believes that such references are now wholly inappropriate and counter-productive towards encouraging a model of care that has produced outstanding positive results. There does not exist at this time any valid reason for singling out the employed NP as compared to the contractual NP, and this proposal only perpetuates a grossly unfair stereotype.

NYAHSAs strongly recommends that this language be rejected and that references to the arbitrary and unfounded distinction between the employed and contractual NP be eliminated in this proposed rule.

NYAHSAs wishes to thank CMS for the opportunity to offer comments on this proposed rule. Please contact me with any additional questions or clarification you may need regarding any of these suggestions at pcucinelli@nyahsa.org or call 518-449-2707 ext. 145.

Sincerely,



Patrick Cucinelli
Senior Financial Policy Analyst

Submitter : Mrs. Lorena Hill
Organization : Lawrence County Manor
Category : Long-term Care

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment.

CMS-1282-P-77-Attach-1.RTF

LAWRENCE COUNTY MANOR

915 Carl Allen Street • Mt. Vernon, Missouri 65712 • 1-417-466-2183

July 11, 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

As a Skilled Nursing Facility (SNF) in rural Missouri, 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*.

Lawrence County Manor is a 90-bed Medicare and Medicaid approved skilled facility. We pride ourselves in being a respected member of the Long Term Care industry since 1966. We employ a team of nursing staff as well as contract with a therapy company that provides all three disciplines: physical, occupational, speech therapies. We are located in Mt. Vernon which is between Springfield and Joplin, Missouri. Mt. Vernon's population is approximately 4,017. The majority of our skilled nursing patients come from Springfield hospitals; which is at least 30 miles from our location. The management of our facility, along with the therapy staff, has analyzed the proposed changes and offers the following insight into the impact on our facility.

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 projecting therapy minutes from the RAI Manual will negatively affect the quality of services provided to the post-acute-stay Medicare patients.

The look-back period as it is currently implemented, allows skilled nursing facilities to "look back" into the hospital stay to gather certain information pertinent to level of care necessary once the patient has been admitted. As it stands, patients admitted to skilled nursing facilities are usually in varying degrees: still weakened and unstable; and not physically capable of participating in therapy programs that are aggressive in the first week in a SNF.

Centers for Medicare and Medicaid Services
July 11, 2005
Page 2

If the hospital look-back is not allowed, it is possible the sickest, weakest patients will not have an appropriate RUG pathway to care.

A reduction or elimination of the grace day period used to set the assessment reference date, specifically for the five-day PPS MDS assessment; and the elimination of the projection of anticipated therapy services during the five-day assessment PPS would also have negative patient care implications.

The discharges from the hospital settings are not under our control. It has been our experience that hospitals are prone to discharge patients in the afternoons (typically on Friday). Regardless of the day of discharge, patients usually arrive here after 1:00 p.m. After an ambulance ride, often 30 minutes or more to our facility, it is inappropriate to expect the new Medicare Part A patient to be able to tolerate all the assessments required by our nursing staff and the rehabilitation therapy staff within the first few hours of admission. Without grace days, the patient would have to be evaluated by a licensed professional therapist on the date of admission. As a non-profit SNF in a rural setting, we are not fortunate to have therapists available seven days per week, thus patients would not be evaluated for rehab therapy needs until Monday following the "common Friday afternoon admission". 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-II rehabilitation group based on anticipated receipt of therapy, we can be paid for the therapy services being provided during the first 14 days after admission.

In summary, we strongly believe that the proposed changes in the look-back period, use of grace days, and projecting therapy minutes would be very damaging to SNF facilities like we are.

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 Lorena Hill, Administrator at 417-466-2183.

Respectfully,

Lawrence County Manor

Submitter : Mr. Steve Higgins
Organization : Central Oregon Health Care Center
Category : Long-term Care

Date: 07/12/2005

Issue Areas/Comments

Issue

Proposed Refinements to the Case-Mix Classification System
See Attachment

CMS-1282-P-78-Attach-1.DOC

CMS-1282-P

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

Submitter:

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

Date: July 8, 2005

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.

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"> ● RUC-ADL 16-18 ● RUB-ADL 9-15 ● RUA-ADL 4-8 | <ul style="list-style-type: none"> ● RUX-ADL 16-18 ● RUL-ADL 7-15 |
| Rehab Very High | <ul style="list-style-type: none"> ● RVC-ADL 16-18 ● RVB-ADL 9-15 ● RVA-ADL 4-8 | <ul style="list-style-type: none"> ● RVX-ADL 16-18 ● RVL-ADL 7-15 |
| Rehab High | <ul style="list-style-type: none"> ● RHC-ADL 13-18 ● RHB-ADL 8-12 ● RHA-ADL 4-7 | <ul style="list-style-type: none"> ● RUX-ADL 13-18 ● RUL-ADL 7-12 |
| Rehab Medium | <ul style="list-style-type: none"> ● RHC-ADL 15-18 ● RHB-ADL 8-14 ● RHA-ADL 4-7 | <ul style="list-style-type: none"> ● RUX-ADL 15-18 ● RUL-ADL 7-14 |
| Rehab Low | <ul style="list-style-type: none"> ● RLB-ADL 14-18 ● RLA-ADL 4-13 | <ul style="list-style-type: none"> ● RUX-ADL 7-18 |

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.

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?

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).

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.

Submitter : Ms. Susan Johnson
Organization : Iowa Health Des Moines
Category : Hospital

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-79-Attach-1.DOC

July 14, 2005

The Honorable Dr. Mark McClellan
Administrator, Centers for Medicare & 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: Proposed Rule (69 *Federal Register* 29070).

Dear Dr. McClellan,

I would like to take this opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule for the fiscal 2006 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) published in the May 19, 2005 *Federal Register*. I am commenting on behalf of Iowa Lutheran Hospital (ILH) located in Des Moines, Iowa. ILH has a 15-bed hospital-based skilled nursing unit and so we are very interested in Medicare changes to SNF reimbursement. My comments are as follows:

Case-Mix Adjustments and Other Clinical Issues

The SNF PPS has been widely criticized for under-reimbursing providers for costly non-therapy ancillary services, such as dialysis, intravenous feeding and medications, ventilator care and prescription drugs. These services are frequently used by medically complex Medicare patients who are commonly treated in hospital-based SNFs. Because we treat so many of these medically complex Medicare patients, our current reimbursement levels do not even cover our direct costs.

ILH supports refinement of the existing classification system in a way that will recognize the higher costs of caring for medically complex patients. There are inherent flaws within the existing RUG-III classification system that create inequities between free-standing and hospital-based SNFs that must be eliminated, but we question whether the creation of 9 additional RUGs will resolve this problem.

CMS is also proposing to add 8.4 percent to the nursing component of the case-mix weights as CMS itself recognizes the proposed nine additional RUGs will not adequately account for the non-therapy ancillary services. By adding the 8.4 percent, the result will be approximately an additional 3 percent in payments to SNFs. Until a broader, more comprehensive refinement is available, CMS should adopt measures to provide relief to hospital-based SNFs and swing-bed providers as they serve a disproportionate share of medically complex patients. The proposed refinements fail to meet the intent of Congress in ensuring adequate payment for medically complex SNF patients. As CMS works toward recognizing the higher costs associated with medically complex patients, we ask that they consider including the use of specialty beds and administration of blood as services that warrant classification into the Extensive Care category.

We recommend that CMS consider weighting the SNF per diem payment through variable per diem adjustments, as applied in the Inpatient Psychiatric Facility PPS. This would result in higher payments earlier in the SNF stay, coinciding with the higher facility costs incurred in the earlier part of the stay. This approach would be a good fit for the SNF PPS since it would acknowledge the higher

costs incurred in the early days of a SNF stay and provide an incentive to treat sicker, short-stay patients in an appropriate setting.

The Skilled Nursing Facility Market Basket Update

In the analysis of the market basket update and in response to the economic impact, this rule indicates that CMS has overlooked one important variable. The increases related to the market basket update and the increase to the nursing component, in combination with the loss of \$1.4 billion in add-on payments, will result in an estimated net \$200 million reduction to SNF providers. SNFs are entitled to receive an inflation increase regardless of whether or not the case-mix classification system is refined.

We urge CMS to ensure the entire \$1.4 billion in addition to a full market basket update for FY 2006 is maintained for SNF PPS payments. Congress did not direct CMS to implement cuts, it directed CMS to refine the existing case-mix classification system, and CMS has yet to do so adequately and fairly.

It would have been very helpful for us in estimating the impact of the proposed changes 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 provisions that would restructure the RUGs. Also, a more detailed impact file with provider numbers, such as the file provided for Inpatient Rehabilitation Facilities, would assist organizations in determining the estimated impact of the proposed rule at the provider level. It is difficult for us to analyze the financial impact of this rule without the information specified above.

SNF Wage Index

Although we support the immediate transition to the Core Based Statistical Areas (CBSAs), we also support the development of a SNF-specific wage index. Currently, wages paid to SNF staff are completely excluded from the wage index calculation and the hospital wage index is applied to all SNFs even though SNF wages may be very different from acute hospital wages.

We urge CMS to begin developing instructions for the collection of SNF wage data, in conjunction with the provider community. Implementing a SNF-specific wage index would allow CMS to better recognize the employment mix among labor markets. A SNF wage index would also more appropriately distribute Medicare payments nationwide.

14-Day Look Back and Five-Day Grace Period Provisions

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 including 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 (the look-back period, grace days, and anticipated therapy) would be very detrimental since they would significantly limit the cases that would be eligible for the proposed new RUGs categories. Hospital-based SNFs cannot absorb any further negative financial effects in combination with the underpayment for non-therapy 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, we continue have concerns about the MDS' inability to capture accurately the information related to short-stay patients, commonly treated in hospital-based SNFs, who are discharged before the standard five day assessment. One possible solution to this issue is to implement an assessment

up-front at the beginning of the SNF stay. This approach would be consistent with MedPAC's testimony provided to the Subcommittee on Health of the Committee on Ways and Means of the U.S. House of Representatives on June 16, 2005. Another alternative would be to allow the SNF to complete the MDS upon the patient's discharge, regardless of whether or not it falls before the five day assessment.

Qualifying Three-Day Inpatient Hospital Stay

This rule requests comments on whether or not an observation stay immediately preceding an inpatient stay should be included in computing the three-day prerequisite acute stay for SNF level of care. Given the changes in the delivery of health care since the creation of the SNF benefit in 1965, it is more common for physicians to admit patients to observation when it is questionable whether or not the patient will require, or meet medical necessity criteria to qualify for an inpatient admission. We support changing the policy to include observation stays immediately preceding an inpatient stay to meet the admission criteria for SNF level of care.

Designing Pay for Performance

In this rule CMS acknowledged that Medicare Part A pays for only a small portion of nursing home care (10 percent) which is not enough to effect broad-scale pay for performance criteria to enhance the quality of care Medicare beneficiaries receive. The agency also wishes to move toward a performance measurement model that coordinates an approach to payment for post-acute services that reaches across settings and focuses on quality of care for the overall post-acute episode, regardless of provider type. This model would require CMS to transition from provider-centric payment approaches to patient-centric approaches based on patient characteristics and outcomes.

Despite the inadequate reimbursement, Iowa hospital-based SNFs and swing-bed providers continue to demonstrate value through the provision of efficient and quality health care services, as evidenced by CMS rankings of Iowa's delivery of quality healthcare as the sixth highest in the nation. For the Medicare program to become a purchaser of value, it must focus on improving the health outcomes for program beneficiaries and more effectively manage the disperse resources that Congress provides.

Any design of paying for the post-acute care episode based on patient characteristics and outcomes must embrace the following principles:

Payment incentives should:

- Reward providers for improving quality and providing effective care.
- Evaluate the consumption of resources in achieving desired health outcomes as this is necessarily required in measuring effective care.
- Use a system of rewards that increases payments and reduces regulatory burdens for successful providers.
- Be aligned between hospitals and physicians.

Performance measures should:

- Be based on measures of adherence to quality improving processes.

- Should be selected to insure that all providers have an opportunity to participate and succeed.
- Be selected to minimize the data collection burden for providers.

Thank you for your review and consideration of these comments. If you have questions, please contact me at 515-241-6290.

Sincerely,

Susan Johnson
Reimbursement Manager

cc: Brenda Long – Executive Director of Rehab Services
Iowa Hospital Association

Submitter : Ms. Diane Carter
Organization : American Association of Nurse Assessment Coordinat
Category : Nurse

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

Page 29081: Implementation Issues

While the proposed rule indicates that payments will be made entirely on the 44-group RUG classification system from October 1, 2004 through December 31, 2004, with the switch to the 53-group RUG classification system effective January 1, 2006, greater specificity regarding this transition is needed. Clarification is necessary regarding issues such as:

1. Payment under the 44-group or 53-group RUG classification system based on date of service versus MDS assessment reference date (A3a) or MDS completion date (R2b) (i.e. claims for dates of service through December 2005 reflect the 44-group RUG classification and claims for dates of service on or after January 1, 2005 reflect the 53-group RUG classification)
2. For MDS assessments that are used to cover skilled services days in both December 2005 and January 2006 (e.g. a Medicare 30-day assessment covering services dates of December 15, 2005 through January 13, 2006)
 - a. Which date triggers the reporting of a 44-group or 53-group RUG classification at MDS item T3a - the service date, MDS assessment reference date (A3a), or MDS completion date (R2b)?
 - b. What documentation trails are facilities to maintain regarding the 44-group RUG assignment and 53-group RUG assignment when an MDS is used to cover services in both December and January?
3. Will the federal MDS edits calculate and accept submission of 44-group RUG classification on MDS correction assessments submitted through April 2006 (covering the 120 day maximum for submitting corrected SNF claims).

III. ASSESSMENT TIMEFRAMES

Page 29082: Clarification of Other Medicare Required Assessments

The discussion of OMRA assessments on page 29082 is very confusing for readers who are not familiar with the CMS history of equating a Medicare assessment !?due date!? with the MDS assessment reference date found at item A3a. Language found in the May 12, 1998 Interim Final Rule (page 26266) and the July 30, 1999 Final Rule (page 41656) clearly discuss OMRA assessments in terms of the !?assessment reference date!?. The CMS RAI Manual (page 2-31) further clarifies:

The OMRA ARD (Item A3a) must be set on day eight, nine, or ten after all rehabilitation therapies have been discontinued. The OMRA must be completed (Item R2b) within 14 days of the ARD.

We strongly recommend the following statements currently found on page 29082 be reconciled with language from the 1998 and 1999 SNF PPS rules and the RAI Manual:

Paragraph 1:

?< An OMRA is due 8 to 10 days after the cessation of all therapy . . .

Paragraph 3

?< . . . and is out of the facility for part of the 8 to 10 day period during which the OMRA must be completed, those therapeutic leave days are to be counted when determining the OMRA due date.

Perhaps a clearer approach to the language would be to state:

Paragraph 1: In order to be completed timely, the ARD of the OMRA must be set on day 8, 9, or 10 after the cessation of all therapy.

Paragraph 2: !Kand is out of the facility for part of the observation period for the OMRA, those therapeutic leave days are to be included in the observation period when setting the OMRA ARD.

Issue

Issue

I. PROPOSED REFINEMENTS TO THE CASE-MIX CLASSIFICATION SYSTEM

A. Page 29078 !V Rehab + Extensive RUGs Groups

While we support the addition of the nine new !?Rehabilitation + Extensive!? RUGs groups as a positive approach to more accurately reimbursing non-therapy ancillary resources utilized in providing care to Medicare Part A beneficiaries, we have significant concerns regarding the impact on this new category of revisions to instructions for MDS data capture discussed on page 29080. In addition, while Table 3a, as amended, is a helpful representation of the new RUGs groupings, it would be most helpful if a more complete description of the new groups was documented in the rule. The 44-RUGs group documentation found on page 26262 of

the May 12, 1998 Interim Final Rule would be a good model, resulting in incorporation of descriptions in the 2005 rule similar to the following:

Category ADL Index End Splits

Rehab Ultra + Extensive

?< Rx 720 minutes/week minimum

AND

?< At least 2 disciplines, one at least 5 days/week

AND

?< Qualify for Extensive Services* RUX 16 !V 18 Not Used

RUL 7 !V 15 Not Used

Rehab Very High + Extensive

?< Rx 500 minutes/week minimum

AND

?< One discipline at least 5 days/week

AND

?< Qualify for Extensive Services* RVX 16 !V 18 Not Used

RVL 7 !V 15 Not Used

Rehab High + Extensive

?< Rx 325 minutes/week minimum

AND

?< One discipline at least 5 days/week

AND

?< Qualify for Extensive Services* RHX 13 !V 18 Not Used

RHL 7 - 12 Not Used

Rehab Medium + Extensive

?< Rx 150 minutes/week minimum

AND

?< 5 days/week across 3 disciplines

AND

?< Qualify for Extensive Services* RMX 15 !V 18 Not Used

RML 7 !V 14 Not Used

Rehab Low + Extensive

?< Rx 45 minutes/week over at least 3 days

AND

?< Nursing rehabilitation 6 days/week, two activities

AND

?< Qualify for Extensive Services* RLX 7 !V 18 Not Used

* Extensive Services qualification based on ADL Sum > 7 and one of the following services:

- o IV Feeding in last 7 days
- o IV Medications in last 14 days
- o Suctioning in last 14 days
- o Tracheostomy care in last 14 days
- o Ventilator/Respirator in last 14 days

Case-Mix Adjustment and Other Clinical Issues

C. Page 29080 !V Revisions to Grace Day Periods

We appreciate the opportunity to comment on the impact of decreasing or eliminating Grace Day periods associated with regularly scheduled Medicare assessments. We strongly oppose these suggested changes to Grace Day periods as we feel the rationale for use of Grace Days addressed on page 2-28 of the RAI Manual and on page 41657 of the July 30, 1999 SNF PPS Final Rule remain valid. Relevant rationale identified in these documents includes:

1. Allowing maximum flexibility for nurses when setting the assessment reference date, thereby lessening the burden of the increased frequency of PPS assessments
2. Allowing beneficiaries a few days to stabilize from the acute care setting, if they need it, and be prepared for the beginning of therapy in the SNF that qualifies for the RUGs Rehabilitation groups, including the two highest rehabilitation groups (Rehab Ultra High and Rehab Very High) that require delivery of a minimum of five days of intensive levels of therapy
3. Allowing therapy minutes or other treatments to be more fully captured on the MDS

D. Page 29080 !V Eliminate Projecting Anticipated Therapy Services

We appreciate the opportunity to comment on the impact of eliminating the projection of anticipated therapy services during the 5-day PPS assessment. We urge CMS not to eliminate this provision. Elimination of provisions for projecting ordered therapies:

1. Removes the ability to accurately reflect intensity of Rehab service delivery below the Rehab Very High levels for short stay (example: resident in SNF for four days, receiving therapy on all days, would not group appropriately to Rehab category without provision for projecting service level), and
2. Without the therapy projection, only therapy minutes delivered in the 7-day observation period as indicated in P1b would be utilized for the RUG calculation. This would reduce the ability to distribute high work volume of Medicare assessments by setting Assessment Reference Date on days 1 !V 5 of stay for residents at Rehab Low, Medium, or High. The resulting RUG level often would not be an accurate reflection of the intensity of care provided.

In addition, while the proposed rule includes provisions to address the financial impact of Medicare RUGs refinement on the provider, the proposed rule is silent to the financial impact significant changes to MDS coding instructions present to reimbursement under state Medicaid programs based on RUGs groupers.

E. Page 29081 !V Automated Medical Record Tools

We fully support CMS' efforts to promote and improve the continuity and quality of healthcare through the use interoperable electronic health record systems and

standardized data. Moving from paperbased records and systems to electronic health records and systems offers significant benefits to the healthcare consumer, provider and payor such as reduction in medical errors, improved use of resources, accelerated diffusion of knowledge, and increased consumer involvement in their care. Long term care providers, like the rest of the health care community, face significant challenges in moving towards an EHR. In addition to the daunting challenges posed by technical obstacles, fiscal resources and staff capacity to implement and maintain fully electronic health records are huge hurdles in an industry known for reimbursement and staffing issues. Federal incentives are needed to accelerate the adoption of interoperable electronic health records and achieve the goals of improved quality, safety, and coordination among healthcare provider

Case-Mix Adjustment and Other Clinical Issues

While the proposed refinements do not add dollars to the reimbursement budget, we remain concerned that the cost of some of the more expensive treatments and services remain prohibitive and can result in access problems for beneficiaries. For example, approximately 50% of the chemotherapy medications are not excluded from consolidated billing and are the financial responsibility of the SNF. In the August 2003 updates to the MDS coding rules, the SNF is no longer able to document on the MDS chemotherapy IV medications in section P or IV fluids in section K given during the observation period. Therefore, the residents will not RUG into Extensive Services but Clinically Complex. IV chemo for a resident in one SNF was \$5,300 for the first 14 days. Clinically Complex (Urban rate) \$246.27 X 14 days= SNF payment of 3,448.82. This leaves a deficit just for the chemo of \$1,851.18. An SE3 would pay \$392.38 X 14 days = \$5,493.32.

We urge CMS to consider further adjustments to the MDS coding rules to allow for classification into RUG levels that provide adequate reimbursement of this type of treatment. We also urge CMS to work with Congress to identify additional exclusions from consolidated billing to help resolve this kind of situation.

Implementation Issues

B. Page 29080 !V Exclusion of Treatments and Programs Performed Prior to Admission

We appreciate the opportunity to comment on the impact of revising the RAI Manual instructions to include only those special care treatments and programs (MDS Section P1a) furnished to the resident since admission or re-admission to the SNF. We strongly oppose this suggested change. While MDS data validity for purposes of Medicare reimbursement of non-therapy ancillary costs may be strengthened, we feel this change will:

1. Have a negative impact on clinical data accuracy for purposes of resident care
MDS Section P1a captures treatments and programs of significant clinical impact irrespective of site of service, such as chemotherapy, dialysis, transfusions, etc. The clinical relevance of the resident receiving these services within the prior 14-days is not diminished by the service occurring prior to admission, and should continue to be reported.

2. Have a negative impact on the clinical proxy used for SNF Medicare presumption of coverage

Page 29080 of the proposed rule states:

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.

It can be presumed that some portion of this !?significant number of residents!? only received skilled benefits because of the !?presumption of coverage!? provisions.

The question becomes, would facilities have skilled those beneficiaries without the look-back instructions that allowed classification of residents into an upper 26 RUG group based on services prior to admission. The July 30, 1999 SNF PPS Final Rule states on page 41668:

Thus, our expectation is that the occurrence of one of the specified events during the !?Ylook-back!?! period, when taken in combination with the characteristic tendency (as discussed above) for an SNF resident!?'s condition to be at its most unstable and intensive state at the outset of the SNF stay, should make this a reliable indicator of the need for skilled care upon SNF admission in virtually all instances. In particular, residents in such situations may need the types of services formerly listed in !? 409.33(a) of the regulations

Often facilities are reluctant to skill residents for the more !?subjective!? skilled services, such as assessment and care planning, addressed at !? 409.33. Therefore, there is concern that beneficiaries who should be covered under Medicare Part A will not receive this benefit due to the perceived higher vulnerability of the provider when skilling under the more !?subjective!? services.

3. Have a negative impact on Medicaid reimbursement in states using any of the RUGs case-mix groupers

While the proposed rule includes provisions to address the financial impact of Medicare RUGs refinement on the provider, the proposed rule is silent to the financial impact significant changes to MDS coding instructions present to reimbursement under state Medicaid programs based on RUGs groupers.

QUALIFYING THREE-DAY INPATIENT HOSPITAL STAY REQUIREMENT

Page 29099 !V Possibility of Counting Observation Time Towards Qualifying Stay Requirement

We would like to voice strong support of any CMS efforts that would expand the technical eligibility requirements for Part A SNF benefits to include hospital observation status in the !?3-day qualifying stay!? definition. Analysis of 1997 !V 2001 SNF and hospital claims data by the Office of the Inspector General identified 60,047 SNF claims that were potentially reimbursed erroneously due to lack of a qualifying 3-day hospital inpatient stay. While this number is significant, it would obviously balloon if it included the number of beneficiaries who did not receive SNF Part A benefits due to appropriate recognition of technical ineligibility by SNF providers.

Submitter : Mr. Graham Adelman
Organization : Cambridge Healthcare Management, LLC
Category : Long-term Care

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-81-Attach-1.DOC

CMS-1282-P-81-Attach-2.DOC

CAMBRIDGE HEALTHCARE MANAGEMENT, LLC

Attachment #81
July 14, 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: CMS-1282-P
- Proposed Refinements to the Case-
Mix Classification System
- Concurrent Therapy

Gentlemen:

Cambridge Healthcare Management, LLC is a Virginia-based, multi-site organization, with Skilled Nursing Facilities ranging in size from 60 beds to 307 beds, including a Transitional Care Unit with 40 ventilator beds, and a heavy focus on complex wound care intervention.

1. Comments on the Impact of Revising 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

Cambridge is not in favor of this proposal for the following reasons:

- By eliminating the ability to capture treatment provided during the final days of the hospital stay, the clinical picture of the patient, as defined in the MDS 2.0, would not fully reflect the time required to provide the intensive level of care for optimal patient management in the SNF setting.
- The hospital setting has historically maintained inpatients for the observation period post-special treatments (e.g. IV medications). But, we have experienced a developing pattern of hospitals releasing those patients immediately following treatment to the SNF setting where the skill level to provide that same service is present. Therefore, the cost of that service is transferred to the SNF setting, which should be reimbursed accordingly, reflecting the financial burden of subsequent care that was initiated in the hospital setting.
- In short, it is well known that, due to payor requirement, hospitals discharge patients to SNF's "quicker and sicker" than when the current MDS Manual Instructions were promulgated. Contrary to the stated purpose of this proposal, by ignoring this reality CMS will ensure the inaccuracy of certain SNF patient classifications, especially those for patients requiring suctioning, tracheostomy care and use of a ventilator/respirator. Intentionally doing so is bound to reduce SNF payments (which are now approximately 50% to 60% of hospital payments for essentially the same services) because it will disregard SNF care obligations.

12093 GAYTON ROAD RICHMOND VIRGINIA 23238

TELEPHONE (804) 521-0550

FAX (804) 521-0555

2. Comments on "Recommendations" to Decrease or Eliminate the Grace Day Period, Specifically for the 5- Day PPS MDS Assessment

Cambridge is not in favor of such a change for the following reasons:

- Since the inception of PPS, there has been a rapidly growing number of patients who do not require long term skilled nursing care, but rather utilize the SNF setting as a "stepping stone" to transition to a lesser level of care environment that is less costly to the Medicare system. Decreasing or eliminating the Grace Days that are currently available for the 5 Day Assessment would have a negative impact on the ability to capture the intensity of rehabilitation services that is clinically appropriate for many of these "short term stay" patients.
- The hospital to SNF transition is a very stressful experience for our patients, in part due to the lengthy, fatiguing and disorienting process of hospital discharge, ambulance transfer, and nursing home admission (including introduction of new care-givers and therapy regimens). It is completely unrealistic to expect a patient to perform adequately during an admission day therapy evaluation to develop an accurate plan of care.
- A maximum 5 day window to determine an ideal RUG category will encourage SNF's to attempt intense therapy sooner than may eventually be determined to be in the patient's best interest (e.g. initiating an evaluation and treatment on the day of admission, regardless of the time of day or the patient's condition). Such practice would negatively impact CMS's professed goal of individualizing each patient's clinical and rehabilitation plan of care.
- In addition, immediate and aggressive intervention provided too early in the SNF stay before the patient has been medically stabilized may prompt an otherwise avoidable readmission to the hospital.
- CMS has not explained the clinical basis for the "recommendations" it has received, disclosed by whom they were made, or enabled the public to assess the qualifications or affiliations of those making them.

Perhaps, as an alternative, a "7 Day Assessment" or "8 Day Assessment" should be established for patients who present with a clinical picture that is indicative of requiring intensive therapy. Criteria for differentiating such patients could be easily derived from actual SNF experience.

3. Comments on Appropriateness of Eliminating the Projection Option for the 5-Day PPS Assessment

Cambridge is not in favor of such change for the following reasons:

- Like the "recommendations" for elimination of Grace Days, eliminating the projection option for the 5-Day PPS Assessment would encourage practice patterns that are guided by reimbursement versus clinical need. Facilities will be financially motivated by CMS to initiate intense therapy intervention on the day of admission, potentially prior to the patient's medical condition becoming stabilized, in order to capture a RUG category that is reflective of the resources needed over the course of the first 14 days.

12093 GAYTON ROAD RICHMOND VIRGINIA 23238

81

- Alternatively, some SNF providers are likely to limit therapy intervention for the first 7 to 14 days in order to reduce the additional cost in labor that will not be realized in reimbursement.
- In either event, it is clearly foreseeable that a large number of SNF's will elect to avoid the patient care/ inadequate reimbursement dilemma which would result from these "recommendations" by reducing bed availability. That, in turn, will require hospitals to maintain patients for longer stays which will be exponentially more expensive for CMS, unless it reduces hospital reimbursement for such stays to the levels it is currently reimbursing SNF's.

4. Comments on CMS Thinking on Designing Pay for Performance Programs for SNF's

Cambridge agrees that some version of linking reimbursement to clinical outcomes is desirable for all constituencies – patient, provider and payor. However, for the following reasons, Cambridge is not in favor of tying the Nursing Home Quality Initiative to reimbursement:

- Cambridge's facilities participate in the Nursing Home Quality Initiative and are strongly in favor of this process.
- MDS generated data does not reflect the improvements resulting from NHQI participation. Rather, it reflects the prevalence of the problem, based on the acuity of each patient's medical condition on admission.
- A pay for performance plan based on this data would likely motivate SNF's to scrutinize admissions in order to minimize high acuity factors. Again, the potential for hospitals to be forced to maintain patients longer in order to decrease acuity will incur a far greater cost to the Medicare reimbursement system.

5. Comments on Adoption of Guidelines to Preclude Inappropriate Provision of Concurrent Therapy

Cambridge is in favor of retaining the position set forth in the Proposed Rules published by CMS in Federal Register, Volume 66, Number 91, Thursday, May 10, 2001, Pages 23991 – 23992 ("Proposed Rules").

- CMS seems to be using anecdotal evidence to justify industry-wide rule-making. Although instances of undue pressure on therapists surely exist, regulatory procedures, including complaint and investigatory mechanisms, also exist to deal with them. Isolated instances of reimbursement abuse should be verified and punished through existing enforcement channels.
- The Proposed Rules clearly recognize the importance of allowing professional judgment to be a guiding force in determining individual patient needs. Specifically, this clarification supports the key principle that "Medicare relies on the professional judgment of the therapist to determine when, based on the complexity of services to be delivered and the condition of the beneficiary, it is appropriate to deliver care to more than one beneficiary at the same time."

- 81
- Indeed, the opportunity to permit a patient to have responsibility for self-directing a brief portion of their treatment program while under supervision of the treating therapist can be a critical factor in gaining the confidence needed to progress to a greater level of independence and safety.

6. Comments on Proposed RUG 53 Expansion

Cambridge is not in favor of this proposal for the following reasons:

- While the Extensive Plus Rehab categories will be more reflective of the clinical and therapy resources needed for those patients who qualify into these categories, the methodology is flawed.
- More SNF's are increasing their skilled ability and willingness to admit patients with complex wounds, and are incurring the associated costs. With the revision of F Tag 314, SNF's are being held accountable for effective and efficient management of wounds, utilizing cutting edge, and more costly, interventions, which again increases the cost to provide optimal care.
- Under the RUG 53 proposal, there would likely be a significant reduction in the reimbursement for this level of care. As a result, SNF's will be less willing to admit patients with complex wounds and hospitals (where most such wounds are acquired) will be required to continue care.

7. Comments on Proposed Redefinition of Criteria for the Qualifying 3-Day Hospital Stay to Include the Observation Period

Cambridge is not in favor of this proposal for the following reason:

- Although this proposal references the significant difference between the level of care rendered in the emergency room and the level of care rendered during the observation period, it does not attempt to endow SNF's with the objective information THEY would need to distinguish the difference between care provided in the emergency room and care provided during the observation period.
- Without this knowledge, SNF's will be less likely to admit a resident who only has clear evidence of a 2 day qualifying stay, for fear that the true clinical picture of the patient is more acute in nature. The outcome is likely to be that hospitals will maintain these "borderline" patients for a longer stay.

In summary, it is clear that the focus by CMS on managing industry costs is detracting from its mission of facilitating quality of care, particularly insofar as its proposals would result in less SNF flexibility to individualize treatment plans. The end result could well be nothing more than an exercise in illogical cost shifting.

Very truly yours,

Graham L. Adelman
Chairman and Chief Executive Officer

12093 GAYTON ROAD RICHMOND VIRGINIA 23238

TELEPHONE (804) 521-0550

FAX (804) 521-0555

Submitter : Mr. Anuj Goel
Organization : Massachusetts Hospital Association
Category : Health Care Professional or Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

Qualifying Three-day Inpatient Hospital Stay Requirement

MHA urges CMS to count days in "observation status" in an acute hospital in calculating Medicare's three-day qualifying hospital stay. As CMS observes in the proposed rule, the acute care LOS has decreased since implementation of the SNF PPS and new acute care services have been developed.

When SNF PPS was implemented CMS did not recognize, "observation status" as an outpatient acute care payment category, and did not incorporate the concept into SNF PPS. Now that's changed and observation is used in nearly all hospitals as 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. Since observation days are experienced by beneficiaries as inpatient days?same beds, same nurses, same ancillaries as patients categorized as inpatient?not to count the days can be confusing and upsetting to beneficiaries and their families. Incorporating a pre-admission "observation status" into the inpatient stay qualifier would permit beneficiaries to transition nursing homes more appropriately.

Issue

Issue

Case-Mix Adjustments and Other Clinical Issues:

We are concerned that the FY 2006 rule does not appropriately correct 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. This failure results in hospital-based SNFs being 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. As CMS noted in the proposed rule, 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.

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, MHA urges CMS to create an outlier pool equal to 3 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.

As a result, 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.

CMS-1282-P-82-Attach-I.DOC



Massachusetts Hospital Association

82

Attachment #82
July 12, 2004

Mark McClellan, M.D., Ph.D.
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1282-P
P.O. Box 8011
Baltimore, MD 21244

RE: CMS-1282-P, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006

Dear Dr. McClellan:

The Massachusetts Hospital Association (MHA), on behalf of our member hospitals and health systems, appreciates this opportunity to comment on two specific issues within the proposed rule for the FY 2006 Skilled Nursing Facility Prospective Payment System (SNF PPS).

Case-Mix Adjustments and Other Clinical Issues:

We are concerned that the FY 2006 rule does not appropriately correct 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. This failure results in hospital-based SNFs being 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. As CMS noted in the proposed rule, 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.

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, MHA urges CMS to create an outlier pool equal to 3 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.

Deleted: 1

Deleted: June 24, 2005

Deleted: Administrator1

Deleted: 500

Deleted: Room 445-G, Hubert H. Humphrey Building

Deleted: 200 Independence Avenue, S.W.

Deleted: Washington, DC 20201§

Deleted: 500-

Deleted: posed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates; Proposed Rule.

Formatted: Space Before: 3 pt, After: 3 pt

Deleted: he

Deleted: 5

Deleted: Inpatient P

Deleted: 1

Formatted: Font: Bold, Underline

Formatted: Font: Bold, Underline

Deleted: intend to

Formatted: Font: Not Bold

Formatted: Normal, Space Before: 3 pt, After: 3 pt, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers

Formatted: Font: Not Bold

Deleted: 2

Formatted: Font: Not Bold

Formatted: Font: Not Bold

82

As a result, 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.

Qualifying Three-day Inpatient Hospital Stay Requirement

MHA urges CMS to count days in "observation status" in an acute hospital in calculating Medicare's three-day qualifying hospital stay. As CMS observes in the proposed rule, the acute care LOS has decreased since implementation of the SNF PPS and new acute care services have been developed.

When SNF PPS was implemented CMS did not recognize "observation status" as an outpatient acute care payment category, and did not incorporate the concept into SNF PPS. Now that's changed and observation is used in nearly all hospitals as 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. Since observation days are experienced by beneficiaries as inpatient days -- same beds, same nurses, same ancillaries as patients categorized as inpatient -- not to count the days can be confusing and upsetting to beneficiaries and their families. Incorporating a pre-admission "observation status" into the inpatient stay qualifier would permit beneficiaries to transition nursing homes more appropriately.

If I can provide you with any additional information regarding our comments, please do not hesitate to contact me at (781) 272-8000, ext. 173.

Sincerely,

James T. Kirkpatrick
Vice President, Health Care Finance and Managed Care,

- Deleted: ¶
- Formatted ... [1]
- Formatted ... [2]
- Formatted: Underline
- Deleted: We are very concerned that [3]
- Formatted ... [4]
- Deleted:
- Formatted: Underline
- Deleted: ¶ ... [5]
- Deleted: consider
- Formatted ... [6]
- Formatted Table
- Formatted ... [7]
- Formatted: Font: Not Bold
- Formatted ... [8]
- Deleted: as a factor ... has ... [9]
- Formatted ... [10]
- Formatted ... [11]
- Formatted: Font: 12 pt
- Formatted ... [12]
- Formatted ... [13]
- Formatted ... [14]
- Formatted: Font: Not Bold
- Deleted: Furthermore, proposed ... [15]
- Formatted: Font: Not Bold
- Formatted: Font: Not Bold
- Deleted: As
- Formatted: Font: Not Bold
- Deleted: has stated in the proposed rule
- Formatted: Font: Not Bold
- Deleted: is a new
- Formatted: Font: Not Bold
- Deleted: service concept not er ... [16]
- Formatted: Font: Not Bold
- Deleted: It has been developed and
- Formatted: Font: Not Bold
- Deleted: to address the challenges of [17]
- Formatted ... [18]
- Deleted: ¶ ... [19]
- Deleted: ¶
- Formatted ... [20]
- Deleted: ¶ ... [21]

82

Page 2: [1] Formatted Anuj K. Goel, Esq. 7/11/2005 3:43:00 PM
 Normal, Space Before: 3 pt, After: 3 pt, Don't adjust space between Latin and Asian text, Don't adjust space between Asian text and numbers

Page 2: [2] Formatted Anuj K. Goel, Esq. 7/11/2005 3:43:00 PM
 Space Before: 3 pt, After: 3 pt

Page 2: [3] Deleted Anuj K. Goel, Esq. 7/11/2005 2:36:00 PM
We are very concerned that several of your proposed changes to the IPPS will have significant negative impacts on our hospitals and the Medicare beneficiaries they care for and we are providing comments on those proposals. We are particularly concerned about the proposed expansion of the post-acute care transfer policy and the potential underestimation of the market basket.

MHA has previously submitted comments on wage index issues, specifically countywide group reclassification criteria and these are attached.

Page 2: [4] Formatted Anuj K. Goel, Esq. 7/11/2005 3:43:00 PM
 Font: (Default) Times New Roman, Underline

Page 2: [5] Deleted Anuj K. Goel, Esq. 7/11/2005 2:36:00 PM

PROPOSED EXPANSION OF THE POST-ACUTE CARE TRANSFER POLICY

MHA opposes CMS' proposal to expand the post-acute care (PAC) transfer policy. In the proposed rule, CMS discusses the possibility of expanding the policy from 30 DRGs to either 223 DRGs (later revised to 231) or all DRGs. CMS proposes to expand the list of DRGs subject to this policy by making substantial revisions to the DRG selection criteria with little justification or evidence.

| <u>Existing Criteria</u> | <u>Proposed Criteria</u> |
|--|--|
| <u>FORMER CRITERIA</u> | <u>PROPOSAL TO CHANGE TO</u> |
| <u>At least 14,000 total post acute transfers</u> <u>Decline of at least 7% over past 5 years in mean LOS of the DRG</u> | <u>At least 2000 total post acute transfers</u> <u>At least 20% of cases discharged to post acute care</u> |
| <u>FORMER CRITERIA</u> | <u>UNCHANGED</u> |
| <u>At least 10% of post acute transfers occurring before mean LOS</u> <u>Mean LOS at least 3 days</u> <u>Both paired DRGs in a CC/non CC set to be included if either meets above criteria</u> | <u>At least 10% of post acute transfers occurring before mean LOS</u> <u>Mean LOS at least 3 days</u> <u>Both paired DRGs in a CC/non CC set to be included if either meets above criteria</u> |

82

| | | |
|--|--|--|
| | | |
|--|--|--|

| | | |
|--|--------------------|----------------------|
| Page 2: [6] Formatted Font: 12 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [6] Formatted Font: 12 pt, Underline | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [6] Formatted Font: 12 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [6] Formatted Font: 12 pt, Underline | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [7] Formatted Space Before: 3 pt, After: 3 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [7] Formatted Space Before: 3 pt, After: 3 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [8] Formatted Font: Not Bold | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [8] Formatted Font: Not Bold | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [9] Deleted as a factor | joek | 7/12/2005 8:12:00 AM |
| Page 2: [9] Deleted has | joek | 7/12/2005 8:13:00 AM |
| Page 2: [10] Formatted Underline | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [10] Formatted Font: 12 pt, Underline | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [11] Formatted Space Before: 3 pt, After: 3 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [11] Formatted Space Before: 3 pt, After: 3 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [12] Formatted Space Before: 3 pt, After: 3 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [13] Formatted Font: 12 pt, Underline | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [13] Formatted Font: 12 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |

82

| | | |
|--|--------------------|----------------------|
| Page 2: [13] Formatted Font: 12 pt, Underline | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [14] Formatted Space Before: 3 pt, After: 3 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [14] Formatted Space Before: 3 pt, After: 3 pt | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [15] Deleted Furthermore, proposed changes in the Inpatient PPS rule related to increasing the number of cases impacted by the "post-acute care transfer policy" and thereby decreasing hospital lengths of stay necessitates making "observation status" part of the three-day qualifying hospital stay for determining the SNF benefit. | joek | 7/12/2005 8:15:00 AM |
| Page 2: [16] Deleted service concept not envisioned when SNF PPS was implemented | joek | 7/12/2005 8:19:00 AM |
| Page 2: [17] Deleted to address the challenges of overcrowding of emergency departments and i | joek | 7/12/2005 8:21:00 AM |
| Page 2: [18] Formatted Font: Not Bold | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [18] Formatted Font: Not Bold | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [18] Formatted Font: Not Bold | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Page 2: [19] Deleted | Anuj K. Goel, Esq. | 7/11/2005 2:27:00 PM |

The revised criteria have no explained relationship to specific policy objectives CMS might have for the changes. And CMS provides no backup data or arguments to justify the changes. For example:

- CMS proposes a sharp drop in the post acute transfer volume that a DRG must have for the policy to apply (from 14000 to 2000, an 85.7% drop). CMS also proposes to add a new criterion that 20% of the Medicare cases for the DRG be transferred to PAC in order for the transfer policy to apply. Both these thresholds seem to have been arbitrarily set to achieve the desired budget results. In section 1886(d)(4)(J) of the Social Security Act directs CMS to focus on those DRGs that have a high volume of discharges to post-acute care and a disproportionate use of post-discharge services. It is inherently impossible for all DRGs, or even 231, to have *disproportionate* use of post-discharge services. The 231 DRGs selected by CMS represent 88 percent of all DRGs with patients discharged to a post-acute care in FY 2004. Clearly 88 percent of DRGs with *any* post-acute care use cannot have *disproportionate* use.

-CMS is capturing DRGs that are not at all *high-volume*. For example, DRG 473 (acute leukemia without major operating room procedure age > 17) has 2070 discharges to post-acute care as compared to DRG 544 (major joint replacement or reattachment of lower extremity) 349,085 discharges to post-acute care. It cannot be argued that while DRG 473 does not have a *high-volume* of discharges to post-acute care, it still has *disproportionate* use. Only 22.7 percent of the cases in DRG 473 were discharged to post-acute care versus 83 percent for DRG 544. **CMS' proposed criteria cast far too wide of a net and capture far more DRGs than appropriate.**

-Minor changes in the criteria will have huge impacts on reimbursement to hospitals. For example, in Massachusetts, MHA analysis shows that the negative impact of the expansion of the PAC policy would be decreased by an estimated 60% simply by increasing the transfer rate criterion to 30% and there would be an 80% decrease in the negative impact by changing the transfer rate threshold to 40%. Without backup arguments or data to support the expansion of the PAC transfer policy, it seems that CMS has conveniently tweaked the criteria to maximize budgetary savings.

- CMS proposes to remove the declining length of stay criterion which is directly relevant to the issue CMS claims to be addressing by expanding the PAC transfer policy. The stated purpose of the IPPS transfer payment policy is to avoid providing an incentive for a hospital to transfer patients to another hospital early in the patients' stay in order to minimize costs while still receiving the full DRG payment. The removal of the "declining LOS" criterion seems to have been done to justify an expansion of the policy where there is no evidence that hospitals are changing behavior (transferring patients earlier) to take advantage of the payment system. In fact, while in implementing the policy for the initial 10 DRGs, CMS included an analysis showing that across almost all lengths of stay for each of the 10 DRGs, hospitals would, on average, be paid in excess of their costs even after the implementation of the provision, we have not seen any such data for the new proposed 231 DRGs. We believe expansion of the provision is just a back door budget cut to hospitals – especially given that Health Economics Research, Inc. in its report of July 31, 2000 showed that short-stay post-acute transfer cases are 7.4 percent more costly than short-stay non-post acute care transfer cases. **While the length of stay may be shorter, the level of services provided during the stay is more intense and costly.**

-The post-acute transfer policy is not necessary, as the perceived "gaming" hypothesis does not exist. When Congress first called for expansion of the transfer policy in the Balanced Budget Act of 1997 (BBA), data showed that Medicare inpatient lengths of stay were dropping, and that both use and cost of post-acute care by Medicare beneficiaries was growing. Since that time, however, inpatient length of stay has stabilized. Medicare spending on post-acute care has slowed as post-acute payment systems have moved from cost-based reimbursement to prospective payment. Additionally, studies by the AHA and others show that the majority of patients who use post-acute care have longer – not shorter – hospital stays than patients who do not use post-acute care, demonstrating that these patients are truly "sicker" and in need of additional care.

P2

-The post-acute transfer policy penalizes hospitals for efficient treatment, and for ensuring that patients receive the right care at the right time in the right place. The policy disadvantages hospitals that make sound clinical judgments about the best setting of care for patients. Hospitals should not be penalized for greater than average efficiency. Particularly, facilities in regions of the country where managed care has yielded lower lengths of hospital stay for *all* patients are disproportionately penalized.

-The PPS payment system depends on the idea of “averaging” where cases with higher than average lengths of stay tend to be paid less than costs while cases with shorter than average stays tend to be paid more than costs. The expansion of this policy simply reduces payments to short stay low cost cases while not simultaneously increasing payments for long stay cases. This makes it impossible for hospitals to break even on patients that receive post-acute care after discharge. Hospitals “lose” if a patient is discharged prior to the mean length of stay, and they “lose” if patients are discharged after the mean length of stay. For all practical purposes, such an extensive expansion of the post-acute transfer policy acts as an across-the-board reduction in Medicare payments. It provides a perverse incentive to extend the stay of the patient beyond that which is clinically appropriate, despite the fact that more specialized attention may be provided in a PAC setting. **It appears that the decision to expand the PAC transfer policy has been done for budgetary reasons and CMS has conveniently tweaked the criteria so that almost all DRGs are now subject to a policy that defies the idea of averaging. This change is being proposed without regard to what the right policy is for beneficiaries and the healthcare system.**

-This is particularly problematic given that more than 50 percent of hospitals are already loosing money treating Medicare inpatients and overall Medicare margins have been dropping every year since 1997 to an estimated *negative* 1.9 percent. The AHA estimates that Massachusetts will have the second highest percentage drop in Medicare payments in the nation, an amount in excess of \$40 million per year. Massachusetts hospitals comprise only 1.8% of the nation’s hospitals but would suffer 4.7% of the impact. This comes at a time when hospitals in the state have had declining Medicare margins for years and more than a third of our hospitals have negative total margins. The drop in Medicare payments due to the expansion of the PAC transfer policy would convert our already slim Medicare margins to negative and would force many more of our hospitals into the red.

We strongly object to an expansion of the post-acute care transfer policy, which is not in the best interests of patients or caregivers. It undercuts the basic principles and objectives of the Medicare PPS and undermines clinical decision-making and penalizes hospitals for providing efficient care, at the most appropriate time and in the most appropriate setting. This provision must be withdrawn in its final rule. Without further review and analysis of the impact on patient care and the impact on other post-acute provider’s ability to provide efficient care, CMS should retain the current criteria for determining the post-acute transfer policy.

PROPOSED REDUCTION IN LABOR-RELATED SHARE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to update the inpatient PPS market basket at least once every five years. CMS proposes to update it every four years, beginning with rebasing and revising the market basket for FY 2006. For FY 2003, CMS rebased the market basket using 1997 data; however, CMS continued to calculate the labor-related share based on the 1992 data. The 1997 data would have raised the labor-related share to 72.5 percent from 71.1 percent, but there was concern at the time that the increase would hurt rural facilities that primarily have area wage indexes (AWIs) below 1.0. *CMS cited the need to conduct additional analyses in deciding to leave the labor related share at the 1992-based 71.1 percent.*

For FY 2006, CMS is proposing to **reduce** the labor-related share from 71.1 percent to 69.7 percent, which is due to the use of more recent data and the removal of postage from the labor-related share. This proposed change, if adopted, would adversely affect hospitals with an AWI greater than 1.0. In the MMA, Congress included a provision that held hospitals with a wage index below 1.0 at a 62 percent labor-related share. The proposed reduction in labor share will have a detrimental affect on high-wage area hospitals while diverting funds back to low-wage hospitals that have already been protected through the MMA

Additionally, we are concerned about the removal of postage from the labor-related categories. CMS's assertion in 2003 that additional analyses are needed still stands today. We believe that CMS should continue to consider this category labor-related until a broader look at the calculation of the labor-related share is taken. We are also concerned about the large drop in the other labor-intensive services category (landscaping, protective services, laundry, etc.). We would urge CMS to investigate this drop and whether it is a result of a flaw in the methodology. For instance, an inappropriately low growth factor could cause an improper category weight and the underestimation of the market basket.

We are concerned about CMS making any changes to the calculation of the labor-related share devoid of a broader plan to refine the methodology. Given that CMS was unable to discover an alternative methodology that is accurate, reliable, and reasonably easy to apply; we believe CMS should leave the labor-related share at 71.1 percent.

MHA urges CMS to leave the labor-related share at 71.1 percent for FY 2006 and recommends that CMS continue investigating alternative methodologies for computing the labor-related share.

82

UNDERESTIMATION OF THE HOSPITAL MARKET BASKET

The hospital update is based on a market basket factor that is intended to reflect the average change in the price of goods and services hospitals purchase to furnish inpatient care. These price changes must be projected forward to estimate increases for the subsequent year so that an appropriate inflationary update can be determined in advance of payment. The payment system is prospective, and the update is not retroactively reconciled to reflect actual price increases for the year. Therefore, a reliable projection methodology is vital to ensure equitable payments.

We are deeply concerned that for 7 of the last 8 years, *the market basket projection has been lower than the actual increase*. While the market basket was over-estimated for a number of years prior to that time, a methodology change was made in 1998 that appears to have over corrected for the previous estimations. CMS reports that, based on the most recent data, the FY 2005 market basket increase is now estimated to be 4.1 percent compared to the projected 3.3 percent increase that was used to determine the update factor. We are concerned that *the methods used to project the market basket increase are flawed and fail to provide a reliable estimate of hospital cost increases*.

We request that CMS review the methodology that was used to determine the projected FY 2005 market basket and revise it for the FY 2006 projection. We also urge CMS to make the details of the calculation available to the public.

HOSPITAL QUALITY DATA

The proposed rule for FY 2006 states several requirements for Hospital Quality Alliance data to be considered submitted for purposes of receiving the full market basket update. These requirements include *the validation of the hospital's 3rd quarter 2004 data*. While MHA supports the need for validation of the data that are submitted for the HQA to ensure that information is being collected and processed similarly, we note that the law only calls for the submission of the data for hospitals to qualify to receive the full payment update. We believe that Congress recognized that taking submitted data and turning it into information that could be publicly reported is a process, and that there could be imperfections in that process. In linking payment to the *submission* of data, Congress suggested that hospital payments should not be held hostage to CMS or its contractors being able to correctly carry out the processing of the hospital data. The fact that all hospitals in Massachusetts a clear majority around the country are actively participating in the data submission process should not be minimized. As a result, we should not be penalized for meeting the basic mandates of the law.

Further, there is enough evidence of flaws in the validation process-data collection, logistics and processing- to suggest that passing additional validation should not be a criterion for receiving the full Medicare market basket update.

Until the validation process is reliable, MHA opposes the proposed link between meeting the validation requirements and receiving the full market basket update. The CMS' validation process is not currently reliable and needs improvement before it is used in determining which hospitals receive full updates.

WAGE INDEX

Wage Index Calculation Change

The inpatient PPS proposed rule for 2006 contained a change in the wage index calculation. This change was made in step 4 of the Computation of the Proposed FY 2006 Unadjusted Wage Index on page 23373 in the *Federal Register*.

The change is in the calculation for Overhead Wage-Related Cost Allocation to Excluded Areas. This calculation is made up of three steps:

Determine the ratio of overhead hours to revised hours.

Compute overhead wage-related cost by multiplying the overhead hour's ratio from step 1 by wage-related costs.

Multiply the overhead wage-related costs by the excluded hour's ratio.

The change in the calculation occurred in step 1. For 2006, the calculation for revised hours was changed to subtract excluded areas (Lines 8 and 8.01). This change results in a higher ratio for step 1, which results in an increase in the overhead cost allocated to excluded areas. This change lowers affected hospitals' average hourly wages.

MHA is concerned that CMS would make such a change to the calculation of the wage index with out any discussion. We request that CMS explain the basis for the change and how a proper allocation can be achieved using the formula set forth in the proposed rule. Providers should be given an opportunity to comment on this revision to the methodology *before* it is implemented. We believe that this methodological revision will have a significant impact on the wage indexes for some hospitals. **Accordingly, we believe that CMS should return to the established methodology and go through the full notice and comment process before making such a change. We further recommend that hospitals be given an opportunity to withdraw or reinstate their requests for geographic reclassification within 30 days of the publication of the Final Rule.**

Out-Migration Adjustment

Hospitals that qualify for an out-migration adjustment and do not waive the application of the adjustment are not simultaneously entitled to reclassification pursuant to Sections 1886 (d)(8) or (d)(10). Because of significant changes to the wage index that took place

in FY 2005, CMS allowed hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the publication of the FY 2005 Final Rule. By doing so, CMS acknowledged that changes made between the proposed and final rules could affect whether a hospital was better off accepting the out-migration adjustment or whether it would be more advantageous for a hospital to waive the out-migration adjustment and pursue geographic reclassification.

Although the changes to the wage index are not as extensive for FY 2006, MHA believes there is still a likelihood that revisions made between the proposed and final rules may impact a hospital's choice of whether to accept the out-migration adjustment or whether to apply for geographic reclassification. Thus, MHA requests that CMS implement a policy similar to last year's that allows hospitals to withdraw or reinstate their geographic reclassification applications within 30 days of the date that the Final Rule is published.

CMS should release and make available the hospital commuting data collected by the Bureau of Labor Statistics (BLS) utilized by CMS in the out-commuting adjustment. While the data are supposed to be on the BLS website, we have been unable to locate it. This information will assist us in verifying the adjustment calculations and aid us in our research of labor market areas.

We **strongly support** CMS' interpretation of the law that hospitals will receive the same outmigration adjustment in each of the three years of eligibility for the adjustment (*42 CFR 412.64(i)(3)(iii): Any wage index adjustment made under this paragraph (i) is effective for a period of 3 fiscal years, except that hospitals in a qualifying county may elect to waive the application of the wage index adjustment*). Especially in the case of FY2006, hospitals have based their decision to withdraw their reclassification by the June 20, 2005 deadline on the specific published amount of their outmigration adjustment and MHA recommends that CMS maintain its policy to keep the out-migration adjustment unchanged to minimize uncertainties and instability in Medicare reimbursement to hospitals.

DSH ADJUSTMENT DATA

Section 951 of the MMA required CMS to furnish the necessary data for hospitals to compute the number of patient days included in the DSH formula. MHA believes that this requirement encompasses the Medicare, Medicaid and Supplemental Security Income (SSI) data used in the DSH calculation. Hospitals can use this information to determine a more accurate calculation of their Medicare DSH adjustment and to determine whether the data based on the federal fiscal year or their own fiscal year is advantageous. **MHA supports CMS' plans to release a MedPAR limited data set for both SSI and Medicare but we strongly object to CMS' decision not to make available Medicaid information.** Congressional intent on the inclusion of Medicaid information is clear. The explanatory report language accompanying the final legislative language for the MMA, states that the Secretary of Health and Human Services must arrange to provide information hospitals need to calculate the Medicare DSH payment formula. This same section in the version of the MMA passed by the House of

Representatives states specifically that the Secretary is required to provide the information to hospitals so they can calculate the number of Medicaid patient days used in the Medicare DSH formula. The hospital field has brought this issue regarding the problems of obtaining Medicaid information from the state programs to the attention of CMS for a number of years. CMS then as now, continues to ignore this problem.

CMS states in the rule that it believes hospitals are best situated to provide and verify Medicaid eligibility information and that the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction. The process for obtaining, reporting, and justifying the Medicaid days is problematic, complex, time-consuming and labor intensive. Moreover, the penetration of Medicaid managed care can add an additional layer of complexity in some states that can further diminish the accuracy of the data provided to hospitals.

We recommend that CMS impose a state Medicaid plan requirement to meet the terms of the MMA provision that requires states to provide timely, accurate Medicaid information and that CMS require states to provide provisions in their contracts with managed care plans that require the submission of accurate and reliable utilization data to the state, and that the state make this information available to the providers and contractor audit staff.

PROPOSED LTC-DRG RECLASSIFICATION AND RELATIVE WEIGHTS

A review of the December 2004 MEDPAR data by a Long Term Care Hospital demonstrated that the proposed 2006 LTCH-DRG weights exclude charges that should have been included, resulting in proposed weight calculations that are lower than they should be. At least two major types of errors are present in CMS' 2004 MedPAR file: 1) errors in the recording and calculation of cases involving interrupted stays and 2) errors in the recording of cases where Medicare benefits were exhausted. By failing to include data from interrupted stays or from beneficiaries who exhaust benefits, the MEDPAR data is only able to document a small percentage of true LTCH cases. This will result in significant under-funding to LTCH providers.

Therefore, the proposal to recalculate LTCH-DRG using truncated MEDPAR data would effectively reduce LTCH FY 2006 payments by 4.7% (thereby eliminating any market basket updates for FY 2006). LTCH providers have relied on the FY 2006 LTCH-PPS final rule provisions to base their payment levels. Such a substantial change in policy without any consideration of the FY 2006 payment adjustments, will destabilize several LTCH providers and their ability to effectively provide care.

To that end, MHA urges CMS to either implement any proposed DRG changes in a budget neutral manner or provide for a “**dampening policy**” similar to that applied by CMS to APCs under the outpatient prospective payment system. By using more recent

data and carefully selecting claims to use in relative weight calculations, a similar dampening policy easily could be and should be considered for application to LTCH-DRG weights.

OTHER ISSUES

Outlier Payments

The rule proposes to establish a fixed-loss cost outlier threshold equal to the inpatient PPS rate for the DRG, including IME, disproportionate share hospital DSH, and new technology payments, plus \$26,675. While this is not a particularly sizable increase from the FY 2005 payment threshold of \$25,800, we are concerned that the threshold is too high. CMS states in the proposed rule that actual outlier payments for 2005 are estimated to be 0.7 percentage points lower than the 5.1 percent of funds withheld from hospitals to fund outlier payments and that the payments in 2004 were 1.6 percentage points lower than the funds withheld. MHA questions the inflation methodology used by CMS in coming up with the proposed threshold and strongly urges CMS to adopt the methodology proposed by AHA in its comments.

Occupational Mix Adjustment-Future Data Collection

The occupational mix adjustment to the wage index was intended to control for the effect of hospitals' employment choices rather than geographic differences in the costs of labor. CMS has indicated that the results of the adjustment were counter to the agency's expectations and that nearly one-third of rural areas and over one-half of urban areas would see a decrease in their wage index as a result of this adjustment. Given the expense, administrative effort and time that hospitals have to put into filling out yet another detailed survey and the fact there are ongoing concerns regarding the data and the impact, **we urge CMS to work with Congress to eliminate this requirement and the adjustment.**

Meanwhile, CMS should release a proposed survey for comment as soon as possible. The sooner the survey is out in the field, the more likely the data will be accurate and reliable. We urge CMS to allow for an appropriate amount of time to develop the survey, provide clear instructions, adapt the systems, collect the data, prepare the survey responses, audit the data, correct the data, and calculate the adjustment. Given that CMS must have the adjustment ready for the FY 2008 adjustment (or the April 2007 proposed rule), **we recommend that CMS release the proposed survey this summer to meet this timeframe and allow hospitals adequate time to prepare for the data collection and reporting.**

Graduate Medical Education- Initial Residency Period

Last year, CMS instituted a new policy for weighting the direct GME resident count for residents that pursue specialties requiring an initial year of broad-based training, such as anesthesiology. The new policy allows the initial residency period to be based on the period of board eligibility for the specialty, rather than the clinical-base year. CMS now

further proposes to base the initial residency period on the period of board eligibility for the specialty when a resident matches directly to an “advanced program” without regard to fact that the resident did not match for an initial clinical base-year training program. This would allow hospitals to be paid an entire full-time equivalent (FTE), rather than half of an FTE for such residents until they are board eligible. **MHA supports this change.**

Determination of Relocation Status of Critical Access Hospitals (CAH)

The proposed rule change to impose restrictions on relocating Critical Access Hospitals provides no advance notice or flexibility for those hospitals to maintain their CAH status. As the sole provider of necessary acute care services in the communities, a CAH should be provided the ability to make additional improvements to its facility in order to provide more efficient care and better patient outcomes. The proposed restrictions will prevent many of these providers to make such improvements.

As a result, MHA urges CMS to remove the “under development” criteria as that has no bearing on a CAHs ability to make such improvements now or in the future. Further, the criteria should provide some flexibility in the measures so that providers would only need to meet 3 out of the 5 measures. However, there should be some additional criteria related to a needs assessment (similar to what is required under the state plans) that shows that the need for the changes and costs related to building in the new area will lead to improved patient care.

| | | |
|---------------------------------|---------------------------|-----------------------------|
| Page 2: [20] Formatted | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
| Space Before: 3 pt, After: 3 pt | | |

| | | |
|-----------------------------|---------------------------|-----------------------------|
| Page 2: [21] Deleted | Anuj K. Goel, Esq. | 7/11/2005 3:43:00 PM |
|-----------------------------|---------------------------|-----------------------------|

Submitter : Doug DeVore
Organization : Regency Pacific, Inc / Hilltop Health Care, Inc
Category : Long-term Care

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attachment.

CMS-1282-P-83-Attach-1.DOC

CMS-1282-P

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

Date: July 8, 2005

Submitters:

| | |
|---|--|
| Doug DeVore Chief Financial Officer Regency Pacific Inc ddevore@regencypacificinc.com | Tim Lehner Chief Operations Officer Hilltop Health Care, Inc tlehner@hilltophealthcare.com |
|---|--|

Michelle Sims, RHIT
Health Information Resource
Hilltop Health Care, Inc.
msims@hilltophealthcare.com

On behalf of Regency Pacific, Inc. and Hilltop Health Care, Inc., we 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.

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

Comments:

We disagree that the implementation of this refined case-mix classification system would better account for medically complex residents, 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 and 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 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 Table 3a.

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.

TABLE 3a.—CROSSWALK BETWEEN EXISTING RUG-III REHABILITATION GROUPS AND THE PROPOSED EXTENSIVE PLUS REHABILITATION GROUPS

| | Current rehabilitation groups | New combined extensive plus rehabilitation groups |
|-----------------------|--|---|
| Rehab Ultra | <ul style="list-style-type: none"> ● RUC-ADL 16-18 ● RUB-ADL 9-15 ● RUA-ADL 4-8 | <ul style="list-style-type: none"> ● RUX-ADL 16-18 ● RUL-ADL 7-15 |
| Rehab Very High | <ul style="list-style-type: none"> ● RVC-ADL 16-18 ● RVB-ADL 9-15 ● RVA-ADL 4-8 | <ul style="list-style-type: none"> ● RVX-ADL 16-18 ● RVL-ADL 7-15 |
| Rehab High | <ul style="list-style-type: none"> ● RHC-ADL 13-18 ● RHB-ADL 3-12 ● RHA-ADL 4-7 | <ul style="list-style-type: none"> ● RUX-ADL 13-18 ● RUL-ADL 7-12 |
| Rehab Medium | <ul style="list-style-type: none"> ● RHC-ADL 15-18 ● RHB-ADL 8-14 ● RHA-ADL 4-7 | <ul style="list-style-type: none"> ● RUX-ADL 15-18 ● RUL-ADL 7-14 |
| Rehab Low | <ul style="list-style-type: none"> ● RLB-ADL 14-18 ● RLA-ADL 4-13 | <ul style="list-style-type: none"> ● RUX-ADL 7-18 |

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 residents who were in those categories will be re-categorized into the new groups, therefore, it can be presumed that we will experience a decrease in reimbursement for the same services being provided currently. Also, it appears that 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 less, even if the resident qualifies for the new, higher RUG, that is supposed to better account for the complexity of care. 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 research 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 residents".

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, using data provided from CMS, 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 inaccuracies.

Also a part of the revenue neutrality impact of the proposed rule is 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 document important information for proper assessment of the resident's condition and adequate planning for the appropriate level of care. We estimate that if these steps were taken an additional \$10-\$12 reduction in the Medicare rates would occur. Elimination of the look-back will impede nursing facilities 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 residents are most unstable, resource intensive, 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 residents 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 modification, 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 (PIa – 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 who 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 resident assessment instrument for post-acute care settings and ensuring that financial incentives result in the best clinical post-acute placement for the resident. Such an integrated payment system must be resident-centric, i.e., based solidly on characteristics and outcomes, and be based on a common resident-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.

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 detailed instructions and provider education regarding the crossover 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?

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 specify if you are referring to the Assessment Reference Date (A3a) or when the assessment must be completed by (R2b).

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 its 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.

These statements, as read, have the potential to imply an indirect relationship where none exists.

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 resident.

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 appropriately address the employees and providers fairly as a whole. We have an example of how the wage scale currently does not work. 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. 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.

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 resident 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

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 problems 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 cannot 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 under funding 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 residents.

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, do 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 residents.

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.

CMS SHOULD exercise its authority to eliminate the requirement of a 3-day hospital stay for SNF coverage.

In conclusion, we believe that the proposals must 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 without the elimination of the funding represented. 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 : Mr. Michael Rodgers
Organization : The Catholic Health Association
Category : Health Care Provider/Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-84-Attach-1.DOC

CMS-1282-P-84-Attach-2.DOC

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

July 11, 2005

Mark McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert Humphrey Building
Room 445-G
200 Independence Avenue, S.W.
Washington, D.C. 20201



Re: CMS -1282-P; Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006 – Proposed Rule

Dear Dr. McClellan:

On behalf of the Catholic Health Association of the United States (CHA), the national leadership organization of more than 2,000 Catholic health care sponsors, systems, facilities and related organizations, we are submitting comments on the proposed regulations, Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006 – Proposed Rule, published in the Federal Register on May 19, 2005.

CHA's longstanding interest in the prospective payment system for skilled nursing facilities (SNFs) arises from service to Medicare beneficiaries in freestanding skilled nursing facilities, hospitals with attached SNFs, and hospitals that do not operate SNFs but rely on community SNFs to meet post hospital needs. As such, CHA seeks a SNF PPS system and a case mix refinement that ensures Medicare beneficiary access to skilled care by adequately reimbursing for the needs of Medicare SNF patients regardless of where they receive their care.

General Comments on the Case Mix Refinement

Since the implementation of the SNF PPS in 1998, CHA has been seeking a payment system that recognizes the costs incurred by medically complex patients as well as the full costs of non therapy ancillary services. CHA has been monitoring closely the work that has been undertaken by the Urban Institute, under contract to CMS to support the Report to Congress on Case

WASHINGTON OFFICE
1875 Eye Street, NW
Suite 1000
Washington, DC 20006-5409
Phone 202-296-3993
Fax 202-296-3997
www.chausa.org

Dr. Mark McClellan/2
July 11, 2005

Mix Refinement. CHA is disappointed that CMS has not issued the findings of the study, or the Report to Congress, to allow a full discussion of the appropriateness and adequacy of the refinement in this proposed regulation in comparison to other approaches that were considered. Instead, CMS has only issued a summary of the data utilized for the Urban Institute analysis.

CHA remains concerned that the proposed refinement does not adequately address the differences in patients cared for by hospital-based and freestanding SNFs. Between 1997-2004, 752 or 35% of hospital-based SNFs have closed. Findings presented at the Technical Advisory Panel (TEP) of the Urban Institute on May 8, 2003 suggested that hospital-based SNFs care for significantly different types of patients with higher acuity and these differences are not fully accounted for in a RUG-based SNF PPS system. In 2003, MedPAC also supported this conclusion by recommending higher update factors for SNF PPS in 2003. In 2004 and 2005, MedPAC has recommended that the Secretary to develop an entirely new classification system for SNFs.

At the TEP meeting on May 26, 2004, CHA saw promise in the New Profiles approach, which develops alternative categories of SNF patients, and does not rely on variables such as the amount of therapy provided for classification purposes. While CHA is not prepared to support this approach, we are supportive of the thorough consideration of all potential case mix refinement approaches that will adequately address the full differences in costs and care between HB and FS SNFs. While CHA appreciates the efforts undertaken by CMS to develop a case mix refinement, CHA does not support the adoption of this refinement until a broader and more comprehensive refinement is available for a full discussion.

The MDS related policy changes proposed by CMS will greatly reduce the ability to classify SNF patients into extensive care and the higher rehabilitation categories, thus reducing the intended goal of the new RUG categories. Should CMS choose to implement the proposed RUG-based case mix refinement, CHA opposes the implementation of the proposed policy changes in the MDS (look-back period, grace days, and anticipated therapy) that were integral to the development of the current RUG weights and classification system. These MDS-related policies were linked to the staff time studies that were used to develop the RUG classes and weights. Any changes in these policies should only be implemented if and when a new case mix classification system is developed and/or new staff time studies are undertaken.

Dr. Mark McClellan/3
July 11, 2005

Specific Comments on Proposed Policies

CHA offers the following specific comments on the proposed SNF regulations.

1. MDS Related Changes

CMS is inviting comments on several aspects of the MDS that lead to the determination of the appropriate RUG classification. Even with the proposed RUG refinement, the underlying approach to RUG classification system is essentially remaining as originally designed, but without the necessary updated staff time studies. Further, classification of patients into RUG groups remains relatively stable since the implementation of PPS, with no evidence of abuse of the current rules defining classification. CMS has offered no analytic or policy rationale for implementing these proposed changes. CHA believes that its provider members are implementing the policies as intended by CMS within the SNF PPS system. **Therefore, CHA opposes all changes to the MDS policies as proposed by CMS.**

◆ **Look-Back Period:**

In the Final Rule of SNF PPS, published in the Federal Register on July 30, 1999, CMS stated the following on page 41688 in response to a comment about the appropriate use of the look-back period:

"We note that the use of the look-back period is essentially a clinical proxy that is designated to serve as an indicator of situations that involve a high probability of the need for skilled care. Thus, our expectation is that the occurrence of one of the specified events during the look-back period, when taken in combination with the characteristic tendency (as discussed above) for a SNF resident's condition to be at its most unstable and intensive state at the outset of a SNF stay, should make a reliable indicator of the need for skilled care upon SNF admission in virtually all instances. In particular, residents in such situations may need the types of services formerly listed in section 409.33 (a) of the regulations, that are discussed more fully below. If it should become evident in actual practice that this is not the case, it may become appropriate at that point to reassess the validity of the RUG-III look-back period in making assignments."

In this proposed regulation, CMS is asking for comments on removing the look-back period and only using MDS data on services provided during the SNF stay itself. The only rationale offered for this proposed policy change is that the use of the look-back period has caused a significant number of patients to be classified into extensive services based upon this provision.

Dr. Mark McClellan/4
July 11, 2005

Removing the look-back period would change the underlying basis of the RUGcase mix classification, which was the definition of each item as it used on the MDS. The look-back period is being used as it was defined and intended by CMS in the SNF PPS final regulation, and is an indicator of the need for skilled care at the start of a SNF stay. There is no rationale provided by CMS in support of the elimination of the look-back period other than its use leads to SNF patients being classified into the extensive care category. **Therefore, CHA supports the continuation of the current policy and requests that use of the look-back period should remain as currently defined in the MDS.**

◆ **Use of Grace Day Period:**

In the Final Rule of SNF PPS, published in the Federal Register on July 30, 1999, CMS offers an explanation for the appropriate use of grace days on page 41657.

"Unlike the routine use of grace days described above, 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 sub categories. Classification into the Ultra High and Very High Rehabilitation sub-categories is not possible unless the sub-category's minimum level of services during the first seven days of the stay.

"We also intended to minimize the incentive for 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."

In the proposed regulation, CMS asks for comments on a proposal to decrease or eliminate the grace days on the 5-day assessment. Our SNF provider members have indicated to us that the use of grace days is within the intended purposes

Dr. Mark McClellan/5
July 11, 2005

described by CMS in the final regulation. In particular, use of grace days gives the flexibility for the patient to stabilize before beginning therapy while also allowing the SNF patient to classify in the appropriate RUG group. **Therefore, CHA supports the continuation of the current policy and the availability of three grace days with the 5-day assessment.**

◆ **Anticipated Therapy**

Page 41662 of the final regulation offers the rationale for use of anticipated therapy in Section T.

“Section T of the current version of the MDS must be included with each Medicare PPS assessment, but in the case of the of a Medicare 5-day assessment, the clinician captures minutes of therapy that are anticipated for the beneficiary during the first two weeks of the nursing home stay. This makes it possible for the beneficiary to classify into the appropriate RUG-III rehabilitation group based upon the anticipated receipt of rehabilitation therapy, even though the assessment is done during the first few days of the SNF stay.”

“We realize that reporting therapy time that has not yet been provided is a significant change for providers, but it is in compliance with the grouper logic and allows the facility to provide the most accurate representation of the services to be provided to the beneficiary during the first assessment period.”

The use of Section T/anticipated therapy is necessary in order to have a “prospective” payment system. CHA members are using this section as intended by CMS when the SNF PPS was designed and implemented. Elimination of the use of Section T/anticipated therapy would interfere with the grouper logic and not allow patients to appropriately classify into a rehabilitation group during the first assessment period. **Therefore, CHA supports the continuation of the current policy and the use of anticipated therapy in Section T.**

2. Use of Observation Days Towards 3-Day Prior Hospital Stay

There is no doubt that hospital admission practices have changed since the creation of the 3-day prior hospital stay requirement for SNF level of care. Time spent in observation status does substitute for a hospital day, particularly when an observation stay is followed by a hospital admission. **CHA urges CMS to count observation days towards fulfillment of the 3-day prior hospitalization requirement.**

Dr. Mark McClellan/6
July 11, 2005

3. Consolidated Billing

CHA urges CMS to periodically update the list of excluded items under SNF PPS using its existing authority and not wait until a proposed regulation is published to do so. In particular, as new chemotherapeutic agents are approved by the FDA the appropriate codes should be automatically excluded. Prosthetic device codes are another area in which codes should be routinely added to the exclusion list without a specific request from SNF providers.

CHA recommends the following items be added to the exclusion list:

| | |
|-------|--------------------------------|
| L4396 | Multipodus ankle foot arthosis |
| L3807 | Wrist Hand Finger Orthosis |
| L3810 | Finger Separators |
| L1930 | Ankle Foot Orthosis |
| A5500 | Diabetic Shoes |
| K0628 | Diabetic Shoe inserts |
| L1832 | Static Knee Orthosis |

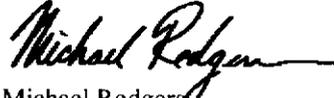
4. Pay for Performance

CHA members also are interested in the potential use of a pay-for-performance system to improve the quality of care provided to all residents of a nursing home, not just SNF patients. However, given the limited number of quality indicators focused on SNF patients and the limited experience with SNF quality indicators, CHA recommends further development of SNF-specific quality indicators before any pay-for-performance system affecting SNF

payment be implemented. CHA wishes to continue the dialogue with CMS on how pay-for-performance might be applied to SNFs.

Thank you for the opportunity to comment on the proposed regulations. If you should have any questions or concerns about our comments, please call Julie Trocchio, CHA senior director continuing care ministries, at 202-721-6320.

Sincerely,

A handwritten signature in black ink that reads "Michael Rodgers" with a long horizontal flourish extending to the right.

Michael Rodgers
Interim President/CEO

Submitter : Mr. Rick Holloway
 Organization : Western Health Care Corporation
 Category : Long-term Care

Date: 07/12/2005

Issue Areas/Comments

Issue

Implementation Issues

There are many areas in rural American that will experience decreases in their wage index, some significant. Critical Access Hospitals located in the same community as the free-standing skilled nursing facility are allowed cost-based reimbursement, and other health care providers were allowed a phase-in of rate cuts. For facilities that experience a decrease in their rate, a three-year phase-in should be allowed. These facilities obviously are not experiencing a decrease in their costs. Although the CMS analysis mentions that only a small percentage of skilled nursing facilities will experience a significant cut in their rates, for those facilities the cuts may put them in jeopardy of closing, or at the very least it will compromise their ability to provide quality care.

Proposed Revisions to the SNF PPS Labor Market Areas

Many areas in Idaho will experience a decline in their wage index beginning October 1, 2005. There was a modification in the manner in which wage indexes were calculated, and several counties in Idaho that were previously considered "rural" are now in a new "micropolitan" designation. However, there are only 7 counties (representing 18 of the 77 Medicare certified SNFs in Idaho and 1,496 out of 5,905 available Medicare beds, according to Nursing Home Compare) where the wage rate increased. Each of these counties is currently located in a county defined as "rural" for the current Medicare rate setting period.

I analyzed the projected impact on the wage rates for all of Idaho, and used the following assumptions to complete my analysis:

1. Average census by facility was at 85 percent occupancy.
2. Average Medicare census of 12.5 percent of total patient days.
3. Idaho State Vet's homes were removed because they are not Medicare certified.
4. Hospital TCU's were assumed to be 100 percent Medicare.
5. The average wage component is \$220 per Medicare day.

Using the above assumptions, I calculated the weighted average net effect of the wage changes to be a decrease of 3.15 percent. Having worked in several facilities all over the state, I do not see how any data could support the conclusion that wage rates decreased by 3.15 percent. The overall decrease in wage index is estimated to result in a \$1.6 million cut in Medicare reimbursement for Idaho skilled nursing facilities during federal fiscal year 2006. At the individual facility level of analysis, however, we could have facilities experiencing increases or decreases in reimbursement from the current year in excess of \$100,000 per year due to changes in the wage index.

Proposed Refinements to the Case-Mix Classification System

I am concerned that the market basket and other increases included in the rates effective 10/01/2005 are not being carried forward to the new 53-group model proposed for implementation on January 1, 2006. I came to this conclusion by comparing the rates for urban and rural counties using the same wage index for rates effective 10/01/04, 10/01/05, and 01/01/06. The BBRA included a provision that the add-ons would continue until the implementation of a case-mix refinement that would better account for medically complex patients. When we examine the change in rates from current to 10/01/05, it seems that the rates do reflect the changes in market basket and wage updates as listed in the Notice of Proposed Rulemaking dated May 19, 2005. However, concerns are noted for rates effective 01/01/06. Examining urban counties only, and holding the wage index constant at 0.98 for all rate periods, there will be only six RUG categories on 01/01/06 with rates higher than 10/01/05, with increases ranging from \$4.24 per day to \$29.03. Three RUG categories have increases in reimbursement of greater than \$20 per day (RMA, RLB, and RLA), while the other three RUG categories experiencing higher reimbursement on 01/01/06 are RMB, RHA, and RHB (\$6.78, \$9.19, and \$4.24, respectively). Conversely, all other RUG categories from CA1 to RUC will see decreases in reimbursement ranging from \$21.06 per day to an incredible \$54.40 decrease in the daily rate for patients in the Extensive Services category of SE3.

The irony in the proposed rates is that the BBRA requires the add-ons to continue until a RUG system can be developed that better accounts for the costs associated with medically complex patients, primary for NTAS. RUG category SE is clearly the case mix category with the highest concentration of patients with high NTAS costs, due to the presence of ventilator-dependent and other complex patients. Many of these patient types will neither qualify for nor benefit from therapy. Thus, the specific type of patient that experiences the highest NTAS costs is the same patient classification with the deepest cuts in reimbursement, a philosophy in direct conflict with the requirements of BBRA.

The calculated rates for the new 53 grouper model shows marked decreases in the per diem rates for the top 26 existing RUG categories with the exception of RHA, RMA, RLB, and RLA. As mentioned above, the most drastic cuts (approximately \$50 per patient day) are in the Extensive Services RUG categories. The nine new RUG categories are supposed to pay for patients who qualify for both the Extensive Services and Rehabilitation RUG categories. However, the proposed RUG category RMX is the only category which experiences a substantial increase in the per diem rate. Using .98 as the wage index and the urban county rate formula, facilities will be paid the following rates for patients who transition from the RUG rates effective on December 31, 2005 to the new categories on January 1, 2006:

| Former RUG(Rate) | New RUG (Rate) | Difference |
|------------------|----------------|------------|
| RLB (\$280.79) | RLX (\$318.82) | +\$38.03 |
| RMC (\$352.44) | RMX (\$421.79) | +\$69.35 |
| RHC (\$357.94) | RHX (\$362.60) | +\$ 4.66 |
| RVC (\$390.30) | RVX (\$401.27) | +\$10.97 |
| RUC (\$506.22) | RUX (\$541.09) | +\$34.87 |

For RLX, RMX, and RUX, the increased rates may reflect the increased costs associated with providing care in that category. But an anomaly is present when

CMS-1282-P-85

comparing RMX to RHX and RVX. The only difference between these categories is the amount of therapy provided. A qualifying patient receiving 150 ? 325 minutes of therapy per week falls into the RMX category at \$421.79 per patient day. If the facility provides between 325 and 500 minutes of therapy per week, reimbursement drops an incredible \$59.19 per day. A facility shouldn't be penalized for providing more therapy. Providing between 500 and 720 minutes of therapy still causes a decrease in reimbursement from the RMX category of \$20.52. This doesn't match the added cost of more therapy.

Submitter : Mr. Graham Adelman
Organization : Cambridge Healthcare Management, LLC
Category : Long-term Care

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-86-Attach-1.DOC

*form letter
81*

Submitter : Mrs. Catherine Reis-El Bara
Organization : Mt. Baker Care Center
Category : Other Health Care Professional

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-87-Attach-1.DOC

form letter
#78

CMS-1282-P-88

Submitter : Dr. David Smith
Organization : American Medical Directors Association
Category : Health Care Professional or Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see attached comments regarding Section VI. Qualifying Three Day Inpatient Hospital Stay Requirement.

CMS-1282-P-88-Attach-1.DOC

CMS-1282-P-88-Attach-2.RTF



July 12, 2005

Attachment #88

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attn: CMS-1282-P
P.O. Box 8016
7500 Security Blvd.
Baltimore, MD 21244-8016

A national organization of
long term care physicians
committed to quality care

**American
Medical
Directors
Association**

10480 Little Patuxent Parkway
Suite 760
Columbia, MD 21044
410/740-9743

Washington, DC
301/596-5774

Toll Free
800/876-AMDA

FAX
410/740-4572

www.amda.com

President

David A. Smith, MD, CMD
Brownwood, Texas

President-Elect

Steven A. Levenson, MD, CMD
Towson, Maryland

Vice-President

Alva S. Baker, MD, CMD
Sykesville, Maryland

Immediate Past President

Daniel Swagerly, MD, MPH, CMD
Kansas City, Kansas

Secretary

Jeffrey B. Burt, MD, CMD
Sutton, Massachusetts

Treasurer

Janice Knebl, DO, MBA, CMD
Ft Worth, Texas

Chair, House of Delegates

Charles Cracelius, MD, PhD, CMD
St. Louis, Missouri

Executive Director

Lorraine Tarnove

e-submission: www.cms.hhs.gov/regulations/ecomments

Re: CMS-1282-P, Three-day Inpatient Hospitalization Stay Requirement

Dear Dr. McClellan,

The American Medical Directors Association (AMDA) is pleased to provide comments on the Proposed Rule for the *Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for Fiscal Year 2006*. AMDA represents more than 7,000 medical directors, attending physicians, and others who practice in nursing homes. AMDA physicians see an average of 100 nursing facility patients per month per member (approximately 8.5 million visits in 2000 or 42 percent of the total number of nursing facility visits that year). AMDA physicians also care for patients in other venues in the long-term care continuum, which includes hospitals, home health care, assisted living settings, hospice and other sites of care for the frail elderly. Our comments on this proposed regulation reflect that experience, as well as the commitment to provide the best quality of care to our patients.

Our comments focus on section VI. Qualifying Three-Day Inpatient Hospital Stay Requirement. The "Prior Hospitalization and Transfer Requirements" in the *Medicare Carriers Manual* state that in order to qualify for post-hospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least three

consecutive calendar days. On July 15, 2004, AMDA joined 18 other organizations in asking CMS to modify Medicare manuals to count all of the time spent by a beneficiary in an acute care hospital for purposes of determining eligibility for Medicare-covered skilled nursing facility (SNF) care. We petitioned CMS's time calculations to include the period of in-patient observation immediately prior to the formal admission as counting toward meeting the SNF benefit's qualifying three-day hospital stay requirement. A copy of those comments is attached for your information.

We are pleased to expand our prior comments. AMDA members directly observe the placement of patients to SNFs and have long opposed efforts that interfere with the timely admission of individuals who require skilled nursing facility level of care versus acute care hospitalization. In an ideal world, inpatient admissions are based on medical necessity. However, actual admission practices may be based upon the availability of beds within hospitals, blurring the distinction in care among various physical locations within hospitals (i.e., emergency room, observation unit). For example, our physicians witness cases of protracted lengths of stay in both Emergency Rooms and Observation Units. Also, the *Proposed Rule* stated "However, the time in the emergency room is not considered a substitute for or equivalent to inpatient hospital care." In some cases, a beneficiary should be admitted as an inpatient, but there is no bed available in the hospital. This may result in the beneficiary remaining in the Emergency Room for 24 hours or more. In other cases, beneficiaries are eventually admitted as an inpatient, but are physically kept in the Emergency Room until a bed is available. The prolonged stay in the Emergency Room shortens the time in inpatient status, but not the total time in hospital. It is the total duration of care in hospital that is more appropriate to use as a criterion of eligibility for post-acute care, rather than the time in a single status (such as inpatient). AMDA physicians note that the care furnished in these other settings within hospitals is often indistinguishable from the inpatient care that follows the formal admission.

In other cases, patients are placed in an Observation Unit because their medical condition needs to be monitored or treated at an intensity that is not provided in the outpatient setting or a unit is inappropriately staffed for its acuity level. Of these patients, some are not found to be acutely ill. They will be discharged from the unit and will not qualify for SNF services. For those

Mark McClellan, M.D., Ph.D.
July 12, 2005

3

who turn out to be acutely ill and are admitted, their medical condition warrants that their whole stay with observation time should be included.

Finally, while AMDA understands that the *Proposed Rule* does not address the elimination of the three-day stay, AMDA's House of Delegates has passed resolution L93 (Became Policy December 1993) that recommends elimination of the three-day stay requirement:

“AMDA resolves that the American Medical Association recommend that the Secretary, in conjunction with health care professionals and skilled care providers, define a subset of patients (or DRGs) for whom the elimination of the 3-day prior hospital stay would avert hospitalization and generate overall cost savings.”

AMDA continues to support this policy.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'DAS', with a long, sweeping horizontal line extending to the right.

David A. Smith, MD, FAAFP, CMD
President

Attachment: July 15, 2004 letter to Laurence Wilson

cc: Laurence D. Wilson, Center for Medicare Management, Chronic Care Policy Group,
laurence.wilson@cms.hhs.gov

CENTER FOR MEDICARE ADVOCACY, INC.
1101 VERMONT AVENUE, NW., SUITE 1001
WASHINGTON, D.C. 20005

(202) 216-0028 FAX (202) 216-0119

ATTORNEYS

Judith A. Stein
Brad S. Plebani
Pamela A. Melico
GHI Deford
Alfred J. Chiplin, Jr.*
Toby Edelman*
Vicki Gottlich*
Patricia Nemore*
Lara K. Stauning
Mary T. Berthelot
Wey-Wey Elaine Kwok*

July 15, 2004

OF COUNSEL

Sally Hart*

*Admitted in other jurisdictions

Larry S. Glatz

ADMINISTRATOR
Carolyn S. Boyle

ADVOCACY COORDINATOR
Ellen L. Lang, R.N., M.P.H.

DATA PROJECT COORDINATOR
Mary Glatz

PARALEGAL
Rebecca F. Ganci

NURSE ADVOCATE
Ellen M. Martineau, R. N.

Laurence D. Wilson
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 20515

Re: Three-day prior hospitalization stay

Dear Mr. Wilson:

The undersigned organizations, representing consumers, health care professionals, and long-term care providers, continue to urge the Centers for Medicare & Medicaid Services to recognize and confirm that the three-day prior hospitalization requirement – a statutory prerequisite to Medicare coverage of a skilled nursing facility stay – is satisfied by calculating all of the time spent by a beneficiary in an acute care hospital. Whether the beneficiary's stay begins with a formal in-patient admission or whether the Medicare beneficiary's stay in the hospital begins in an emergency room or with a period of in-patient observation, followed by a period of in-patient status, we urge the Department to recognize that the beneficiary has met the statutory three-day prior hospitalization requirement if his/her total time in the hospital equals or exceeds three days.

As we wrote you last year, we believe that no change in law or regulation is necessary. We seek modifications only in CMS' Medicare manuals to make them recognize and conform to contemporary medical practice. 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.

The Medicare statute authorizes coverage of a stay in a skilled nursing facility for a beneficiary who, among other statutory prerequisites, has a three-day hospital stay prior to the SNF stay. Under contemporary medical practice, a Medicare beneficiary's in-patient stay in a hospital may begin with an emergency room visit or with a period of in-patient observation. For purposes of satisfying the three-day prior hospitalization requirement, however, initial components of hospitalization are treated separately from the beneficiary's in-patient stay. The result is that a beneficiary who is treated in the emergency room or who is on "observation status" and who then continues treatment following formal admission to in-patient status may not satisfy the three-day prior hospitalization requirement for purposes of the SNF stay, even when he/she has been in the acute care hospital – and treated for a single condition – for more than three days.

When we wrote you last year, the Inspector General was in the midst of issuing a series of reports suggesting that Fiscal Intermediaries recoup Medicare payments when beneficiaries did not satisfy the three-day prior hospitalization stay because an early part of the beneficiaries' three-day hospital stay occurred in the emergency room or when the beneficiaries were under observation status. We understand that the Inspector General is no longer requesting that CMS recoup those payments. While the Inspector General's decision eliminates concerns about skilled nursing facilities' and beneficiaries' being required to repay the Medicare program, beneficiaries' access to care and services nevertheless 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.

We urge CMS to revise its manuals to count all the time spent by a beneficiary in an acute care hospital for purposes of determining eligibility for Medicare-covered SNF care. Thank you for your prompt attention to this matter.

Sincerely,

Toby S. Edelman
Center for Medicare Advocacy, Inc.

On behalf of

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
National Senior Citizens Law Center

Submitter : Ms. Carol Kroboth
Organization : Medical Facilities of America, Inc.
Category : Other Health Care Professional

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

Consolidated Billing Exclusions (Pages 29097 - 29098) We understand the intent of consolidated billing exclusions is to protect SNFs from high cost and / or low probability events that exceed the PPS rates. Drugs seem to be one area that additional exclusions should be provided. Perhaps the average drug wholesale prices could be reviewed on a quarterly basis, and the high cost drugs could be considered for exclusions. Two specific high cost drugs are aranespt and neulasta, which are commonly prescribed for patients undergoing chemo therapy treatments.

Issue

Proposed Refinements to the Case-Mix Classification System

Proposed Pay For Performance (Pages 29080 - 29081) Quality of care is important to each patient in a skilled nursing facility. Use of financial incentives can be used to help encourage providers to continue efforts to improve quality of care. If incentives are offered for quality of care it will be important to establish quality indicators that are very clear and leave little room for interpretation. If the incentives are based upon self reported quality indicators, a verification system will need to be in place.

Case-Mix Adjustment and Other Clinical Issues

Proposed Unification of the Post Acute Care Payment Systems (Page 29081) SNFs, LTACHs, HHAs and IRFs are recognized by Medicare as individual post-acute programs. To accommodate the program variances and regulatory requirements for each of the programs, patient assessment requirements currently vary between these programs. As we move toward an Unified Post Acute Care Payment System it is extremely important to recognize the current program variances and make accommodations for these variances in an all inclusive assessment tool.

Submitter : Ms. Sharmila Sandhu
Organization : American Occupational Therapy Association
Category : Health Care Professional or Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

The American Occupational Therapy Association (AOTA) represents approximately 35,000 occupational therapy professionals, many of whom work in skilled nursing facilities (SNFs). We are pleased to submit the attached comments to CMS. (See attachment)

CMS-1282-P-90-Attach-1.DOC

CMS-1282-P-90-Attach-2.DOC

Via online submission

Via first class mail

July 12, 2005

Centers for Medicare and Medicaid
Department of Health and Human Services
Attn: 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

Dear Sir or Madam:

The American Occupational Therapy Association (AOTA) represents approximately 35,000 occupational therapy professionals, many of whom work in skilled nursing facilities (SNFs). We appreciate the opportunity to comment on the proposed update to rates and policies affecting the SNF prospective payment system (PPS). The notice titled Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006 (hereinafter "Proposed Rule") was published in the *Federal Register* on May 19, 2005 (70 Fed. Reg. 29070).

AOTA presents the following comments on the SNF PPS Proposed Rule:

I. Policy Modifications Regarding the Minimum Data Set (MDS)

In the Proposed Rule, CMS has elicited public feedback on three aspects of the MDS: 1) whether the look-back period should be eliminated; 2) whether the grace day periods for the PPS MDS should be decreased or eliminated; and 3) whether it would be appropriate for CMS to eliminate the projection of anticipated therapy services during the 5-day PPS assessment.

1. Elimination of the Look Back Period

AOTA is concerned that the removal of the look-back period to the hospital stay from the 5-day and 14-day PPS MDS assessments would negatively impact the quality of care for SNF beneficiaries. The look-back period for rehabilitation counts actual days and minutes of therapy back from the Assessment Rehabilitation Date (ARD) for the previous 7 days to determine the appropriate RUG category and treatment needs (i.e., number of days of treatment) of the beneficiary.

The look-back into the hospital stay provides valuable clinical information that influences the plan of care for therapy, including selecting intervention approaches, setting therapy goals, establishing therapy frequencies, intensities and duration, and expecting outcomes. This information

is particularly necessary to ensure that beneficiaries' needs for rehabilitation services (including occupational therapy) are identified and made available to the beneficiaries. In fact, CMS itself has stated that "our expectation is that the occurrence of one of the specified events during the 'look-back' period, when taken in combination with the characteristic tendency for an SNF resident's condition to be at its most unstable and intensive state at the outset of the SNF stay, should make this a reliable indicator of the need for skilled care upon SNF admission in virtually all instances."¹

The omission of the information that otherwise would be garnered from the look back period data could hinder the timely provision of occupational therapy and other skilled services to beneficiaries. Frequently, ill elderly beneficiaries have several comorbidities and have received extensive medical interventions prior to SNF admission. These factors can be good indicators of beneficiaries who require observation upon admission to a SNF to monitor their medical status. If these factors are not adequately considered, it could result in increased readmissions back to the acute care setting and ultimately higher costs to the Medicare program. For these reasons, AOTA recommends that CMS retain the current look back periods in the MDS.

2. Changes to Grace Days

AOTA similarly is concerned that the elimination of or reduction in the number of grace days associated with all PPS MDS assessments would impact beneficiaries' access to quality care. SNFs currently are permitted to use grace days to delay completion of the MDS, and ultimately to delay the initiation of therapy services. The grace days serve an important role in ensuring that those beneficiaries who need extra time to stabilize from the acute care setting are not rushed into too high a level of rehabilitation. The grace days also help to ensure that beneficiaries receive the level and quality of rehabilitation care that they need. The removal or reduction of grace days may result in beneficiaries receiving either too little or too much therapy, when it would have been better to wait to begin their therapy services after they have better acclimated to the SNF, had changes made to their medications in anticipation of therapy services, or important test results had been received. Finally, rushing beneficiaries into therapy prematurely could compromise the outcomes of therapeutic intervention. AOTA recommends that CMS make no changes to the current grace day policy.

3. Elimination of Projected Therapy Services

AOTA also is concerned that the elimination of the projection of anticipated therapy services during the 5-day PPS assessment would impact beneficiary's access to quality care. The projection of anticipated therapy services during the assessment is used to determine the overall picture of the amount of therapy that a beneficiary will likely receive throughout the SNF stay. This evaluative step in the MDS is crucial, particularly for beneficiaries who during their first 14 days are only able to tolerate a small amount of therapy but later would be ready for significantly more therapy. Cutting this projection could result in a mismatch of the plan of care with the beneficiary's needs, a mis-allocation of the therapy resources that the beneficiary requires, and financial pressure to provide less care than the beneficiary needs. AOTA recommends that CMS retain the projection of anticipated therapy services during the assessment.

¹ Federal Register, Vol. 64, No. 146, at p. 41668-69.

Finally, AOTA is concerned that changes to CMS policy that would individually reduce or eliminate the look-back period, the grace period, or the projection of anticipated therapy services, or result in a combined elimination or reduction of all three of these aspects of the MDS would significantly impact beneficiary's access to appropriate occupational therapy services. Each of these mechanisms operates to gather as much accurate and predictive data about beneficiaries as possible to ensure the appropriate allocation of SNF resources, particularly with regard to the provision of therapy services. In a payment system that relies heavily on predicting beneficiaries' anticipated needs for therapy services, limiting or removing these data gathering mechanisms puts beneficiaries at risk of ultimately not receive the therapy and other skilled services that they require and risks the overall quality of the services provided to beneficiaries.

II. Pay for Performance

The desire to simultaneously achieve efficient health care delivery and optimum outcomes is not new, but the speed at which policymakers seem to want to implement a complete program belies the complexity of designing and implementing appropriate systems. AOTA is supportive of ideas in legislation currently in Congress to adopt measures of the functional status of individuals in skilled nursing facilities as part of a pay for performance approach. Function is the principal domain of occupational therapy and occupational therapy practitioners in skilled nursing facilities would be important components of any data gathering in this area. However, AOTA requests that CMS evaluate appropriate research studies and data in formulating the performance goals and requirements for payment under this system, and where no appropriate studies exist, AOTA requests that CMS utilize the needed time and resources to implement the studies and obtain the necessary data. As CMS notes in the Proposed Rule, Pay for Performance is a large scale program which will have a huge impact on all practitioners, including therapists, and therefore should not be advanced without the appropriate evidence on outcomes.

III. Concurrent Therapy

CMS has invited comments 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." AOTA is supportive of efforts to ensure the integrity of the Medicare program and believes that oversight through the Health and Human Services Office of Inspector General (HHS OIG) should continue. The HHS OIG should be involved in reviewing the hiring and billing practices at facilities where abuse of concurrent therapy is suspected. In addition, CMS and its contractors should provide educational outreach to facilities in this area. As part of this outreach effort, occupational therapists working in SNFs should be informed of mechanisms for reporting abusive practices.

AOTA appreciates CMS' concerns that therapists could be pressured to make treatment decisions that compromise their clinical judgment. AOTA is pleased that CMS has recognized that concurrent therapy may be clinically justified. It is imperative that occupational therapists and AOTA have the discretion to address practice guidelines for using concurrent therapy, as they do with other types of practice issues. A coverage or payment policy is not the appropriate place to address these concerns. AOTA encourages CMS to continue to detect abusive practices in the usual

manner, that is, through focused medical review, audits, and investigations through the Office of Inspector General.

* * * * *

AOTA requests that due consideration be given to these comments. Thank you, again, for the opportunity to comment on this Proposed Rule. AOTA looks forward to a continuing dialogue with CMS on coverage and payment policies that affect the ability of occupational therapists to provide quality care to Medicare beneficiaries.

Sincerely,

Sharmila Sandhu, Esq.
Regulatory Counsel

Submitter : Ms. Sharmila Sandhu
Organization : American Occupational Therapy Association
Category : Health Care Professional or Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

The American Occupational Therapy Association (AOTA) represents approximately 35,000 occupational therapy professionals, many of whom work in skilled nursing facilities (SNFs). We are pleased to submit the attached comments to CMS. (See attachment)

CMS-1282-P-91-Attach-1.DOC

Sharmila Sandhu
90

Submitter : Mr. David Storto
Organization : Partners Continuing Care
Category : Other Health Care Provider

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-92-Attach-1.DOC

Electronically

July 12, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 443-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Attention: CMS-1500-P

Dear Dr. McClellan:

Partners HealthCare System, Inc. is pleased to comment on the Proposed Rule for the Medicare Program: Changes to the Skilled Nursing Facility Prospective Payment Systems and Fiscal Year 2006 Rates, as published in the May 4, 2005 Federal Register, on behalf of its member skilled nursing facilities:

| <u>Institution</u> | <u>Provider Number</u> |
|--|-------------------------------|
| Boston Center | 225014A |
| North End Nursing Home | 225506 |
| Shaughnessy-Kaplan Rehabilitation Hospital | 225244 |

Proposed Revisions to the SNF PPS Labor Market Areas**1. Support of the CBSA change**

We support the adoption of the revised "core-based statistical areas" (CBSA's) for purposes of determining labor markets for the area wage adjustment. The refinements proposed by OMB are the result of an extensive review over several years of the criteria used to establish these socio-economic areas. This review process provided ample opportunity for the industry and any other interested parties to provide comments. The Boston MSA, as currently defined for the purposes of payments to SNFs, encompasses an area with diverse labor markets, spanning north to include three counties in New Hampshire, west to Worcester and south to Fall River. The wage differentials within this area are dramatic. We strongly believe that CBSA's provide significantly better measures of individual labor markets and fully support their adoption.

2. Transition

To be clear, we fully understand that this long overdue correction in how CMS defines labor markets will “redistribute” dollars from some providers to others. We noted carefully CMS’ discussion regarding potential transition approaches and appreciate CMS attempt to strike a balance between providing transition relief to a small set of providers and limiting the payment reduction to all providers necessary to “fund” that transition relief in a budget neutral manner. Partners’ SNF providers represent both ends of the spectrum:

- The Boston Center and North End SNFs, located in the Boston CBSA, will experience a 3.5 percent increase in their AWI, compared to that of the Boston MSA;
- Shaughnessy-Kaplan Rehabilitation Hospital, on the other hand, will experience a 5.6 percent decrease in its AWI, among the small percentage (4 percent) of providers CMS cites as experiencing declines in their AWI of 5 percent or more.

We acknowledge the reasons CMS provides for rejecting transition options 1 and 2. We strongly believe, however, that some level of transition protection is warranted. We suggest that CMS approach this by first determining a modest budget neutrality reduction to the standardized amount – we recommend a reduction no greater than 0.15 percent. (For example, what percent reduction to the standardized amounts would be necessary to cap AWI reductions at 3.9 percent, equivalent to a rate reduction equal to the market basket of 3.0 percent, equal to 3.9 percent times 76 percent labor share.) Once the standardized amount reduction is established, we recommend that CMS distribute this “transition pool” to those providers experiencing the greatest reductions in the AWI.

Proposed Refinements to the Case-Mix Classification System

1. Refinements to the case-mix system

We are cautiously optimistic that the proposed RUG refinements will better recognize the resources our complex patients require. We support a delay in implementation, as this will be required for our providers to learn and implement the new categories. At this time, we believe the proposed effective date of January 1, 2006 will give us sufficient time to implement – we ask CMS to consider all comments and monitor this closely, however, and not hesitate to propose a further delay if it deems it warranted.

2. Automated medical record as a mean to provide continuity of care

We welcome CMS’ invitation for comments regarding improvements in the coordination of care, including discharge planning. In particular, we commend CMS for not limiting ideas for improvement to those that can be implemented within CMS’ current statutory authority. The overriding concern of all of us, CMS and providers alike, should always

be improving the care provided to beneficiaries. As such, our overriding assumption should always be that we, including, of course, Congress, will find a way to bring all ideas for improving beneficiary care to fruition.

In this spirit, Partners would like to bring to CMS' attention our efforts over the past two years developing a web-based product called "4-Next" that, we believe, significantly enhances coordination of care by streamlining the flow of patient information from the acute setting to SNFs. 4-Next is an automated facility search program that aids the placement of a patient from an acute inpatient setting to a non-acute setting. 4-Next is an interactive database that contains information on every non-acute provider (including LTCH, IRF, SNF and HH) in the nation and in-depth information on New England providers so that the transferring provider can search for an appropriate care setting by requesting a match as broad as by locality and provider type (e.g., SNF within 20 miles of Burlington, VT that provides cardiac rehab) to as specific as diet preference. 4-Next is also capable of transferring appropriate clinical information on the patient thereby accelerating the admission decision from the receiving facility.

Partners is developing 4-Next because it improves patient care – fulfilling our mission of the "right care, at the right time, in the right setting". Yet, this development has a significant cost. We are encouraged by CMS solicitation of comments regarding "payment reforms that could promote and reward such continuity, and avoid the medical complications and additional costs associated with re-hospitalization." While we are not prepared to provide specific comments at this time, we believe such payment reforms can successfully be crafted – furthermore, as an integrated health care delivery system, we believe we can provide useful input on such reforms and would be glad to do so. We encourage CMS staff to contact Maureen Banks, Project Director for 4Next, at 617 726-4220 or e-mail (mbanks2@partners.org) to learn more about 4-Next and to begin discussions regarding continuity of care payment reform.

Qualifying Three-Day Inpatient Hospital Stay Requirement

We strongly urge CMS to include hospital "observation days" toward the three-day hospitalization requirement for SNF care eligibility. We agree with the assertions of our colleagues that "the care furnished during observation may be indistinguishable from the inpatient care that follows the formal admission" – in fact, in some cases, observation care is more intensive than the subsequent inpatient care. We believe that Congress intended the 3-day standard to be a care standard, not a reimbursement standard, which, observation services are. Finally, we disagree with CMS' drawing a parallel between observation care (and costs) and "certain preadmission costs" and concluding that time spent in observation should not be counted. We again argue that observation care is the equivalent of inpatient care, not "pre-admission care", and therefore falls within the criteria intended by Congress in establishing this benefit.

Consolidated Billing

We welcome CMS call for comments regarding consolidated billing. We would like to take this opportunity to provide a more general comment regarding the recognition of high-cost, low probability events and ask that CMS consider our comment despite the fact that it does not specifically apply to the current statute and regulations regarding consolidated billing.

As CMS knows, high-cost, low probability events occur during Medicare covered SNF stays that are not addressed by the consolidated billing service exceptions. As CMS also knows, there is no protection for providers under the current SNF PPS for such events, e.g., an outlier mechanism. We ask CMS to consider other mechanisms by which it can recognize low-probability, high-cost events within the constraints of the statutory authority it has been given under SNF PPS. One approach for consideration would be for CMS to recognize high-cost SNF events in a manner similar to that used to recognize the costs of ECT treatments in the recently implemented Inpatient Psychiatric PPS. We believe CMS could implement such an approach under its statutory authority to adjust for differences in casemix.

On behalf of all the skilled nursing facility providers of Partners HealthCare System, I thank you for the opportunity to comment on this proposed rule. Please feel free to contact Virginia Mirisola by phone (617-726-4275) or email (vmirisola@partners.org) should you or your staff have any questions or would like more information.

Sincerely,

David Storto
President
Partners Continuing Care

Submitter : Mr. Raymond Sweeney
Organization : Healthcare Association of New York State
Category : Health Care Professional or Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see HANYS' comments attached.

CMS-1282-P-93-Attach-1.DOC



Healthcare Association
of New York State

Attachment #93

July 12, 2005

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 FFY 2006; (70 Federal Register 96, May 19, 2005)

Dear Dr. McClellan:

The Healthcare Association of New York State (HANYs), on behalf of our more than 550 hospitals, nursing homes, home health, and other health care providers, welcomes the opportunity to comment on the proposed rule related to the Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS).

Case-Mix Adjustment and Other Clinical Issues

HANYs supports the Centers for Medicare and Medicaid Services' (CMS) effort to begin to implement fundamental changes in the SNF PPS case-mix system. However, HANYs believes that eliminating the Balanced Budget Refinement Act-mandated temporary payment add-ons --worth six percent-- and replacing it with case-mix refinements and a nursing weight add-on, collectively worth three percent, results in a decrease in overall Medicare payments of three percent, that will worsen a financial hardship currently experienced by SNFs, especially hospital-based SNFs, as evidenced by their 2003 Medicare margins.

As part of its reasoning in proposing this change, CMS indicated that "SNF PPS rates have generally covered the cost of care to Medicare beneficiaries" and that the estimated 2005 Medicare margin for freestanding SNFs was 13%. This estimated margin was included in the March 2005 Medicare Payment Advisory Commission

Mark B. McClellan, M.D., Ph.D.
July 12, 2005
Page Two

report; 2003 cost report data were used to project this margin. Alarming, the same report indicated that the 2003 Medicare margin for hospital-based SNFs was minus 87%. The report indicated that this might be because “hospitals have higher cost structures than freestanding nursing homes.”

The proposed case-mix refinements can be separated into two components. First, there is the addition of nine Resource Utilization Group (RUG) categories to better account for the medical complexity of certain residents in the “Rehabilitation” category who also have conditions that would otherwise place them in the “Extensive Services” category. HANYS applauds CMS’ effort to address the inequity in payment regarding this segment of nursing home residents. HANYS supports the proposed increase to 53 RUG groups and the subsequent case-mix index re-weighting. This component is budget neutral, however, and does not make up for any of the value of the temporary add-ons being eliminated.

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

While we support CMS’ effort to rectify a long-standing deficiency in the SNF PPS case-mix system — namely, as CMS stated in the proposed rule, “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 three 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.

The net effect of these proposed changes would be a three percent reduction in Medicare payments. HANYS believes that it was not the intent of congressional framers to replace the temporary add-ons with adjustments of lesser value.

Proposed Refinements to the Case-Mix Classification System

AIDS Add-On

HANYS concurs with CMS that the expiration of the temporary add-ons does not necessarily affect the temporary 128% acquired immunodeficiency syndrome (AIDS) add-on. Therefore, we agree with CMS’s decision to retain the add-on for federal fiscal year (FFY) 2006.

Revision to the 14-Day “Look-back” Provision

CMS analyzed four items in the “Special Services” section of the Minimum Data Set (MDS) that

Mark B. McClellan, M.D., Ph.D.
July 12, 2005
Page Three

classify residents into the Extensive Services RUGs category and that have a 14-day look-back period: intravenous medications, suctioning, tracheostomy care, and the use of a ventilator or respirator. CMS noted in its analysis that many residents are classified into Extensive Services solely because of the receipt of such services in the acute care setting before 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.

HANYS 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 resident and costs of care in nursing homes for the first few days post-admission.

Many nursing home residents newly admitted from acute care have significant medically complex needs and are in a fragile clinical condition. The first post-admission days in long-term care are an intense period of adjustment for both staff and resident. Staff are intent on gathering detailed information about the resident’s prior stay, the treatment the resident has received, monitoring the resident’s response/residual effects to that treatment, and evaluating the resident’s response to transfer to the nursing home. These intensive activities are critical to determining an appropriate initial plan of care for the resident. 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 resident during the first few days of transitioning between settings.

HANYS would support a comprehensive study 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. However, until a study is done, HANYS does not support any proposed change to the current look-back provision.

Elimination of Grace Days for Five-Day PPS MDS Assessment

The five-day grace period is an option providers can exercise in determining the assessment

reference date (ARD) of the first PPS MDS assessment. The goal is 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.

HANYS believes that these grace days should not be eliminated and should remain 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 nursing home resident's stay post-admission from the acute care setting are an intense period of information gathering, assessment, care planning, and monitoring of the resident. Providers should continue to have the option and flexibility of using grace days to set an ARD sometime within the first five days of admission.

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

July 12, 2005

Page Four

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

Due to a severe shortage of physicians, many nursing homes, particularly those in distressed urban and remote rural areas, struggle to provide medical services. The use of physician extenders such as nurse practitioners (NPs) and clinical nurse specialists (CNSs) has become critical to maintaining adequate and competent health care coverage in facilities. In addition, research has documented that having NPs and CNSs participate in the care of long-term care residents improves quality of care and resident outcomes. In addition, these professionals are essential educational resources for the interdisciplinary care team. HANYS 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), Code of Federal Regulations, 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." The phrase "physician on the SNF staff" 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 residents. If CMS permits physicians in each of these relationships to conduct certification/recertifications without presuming a conflict of

interest, why would CMS expect NPs and CNSs 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.

HANYS urges CMS to reconsider its interpretation of 424.20(e)(2) 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 adjustments. 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.

Mark B. McClellan, M.D., Ph.D.
July 12, 2005
Page Five

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 effects on SNFs. We urge CMS to provide the same transition as was applied to the Inpatient PPS.

Under the new area designations, some facilities that were previously classified as urban being were 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

HANYS commends CMS for considering "observation status" in an acute hospital as a factor in calculating Medicare's three-day qualifying hospital stay. As CMS observes in the proposed rule, the acute care length of stay has decreased since implementation of the SNF PPS and new acute care services have been developed. HANYS believes "observation status" should be made part of the

three-day qualifying hospital stay for determining the SNF benefit.

As CMS stated in the proposed rule, “observation status” is a new acute care service concept not envisioned when the 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 to nursing homes more appropriately.

HANYS urges CMS to adopt “observation status” as part of the qualifying hospital stay requirement for determining eligibility for the SNF benefit.

HANYS appreciates the opportunity to comment on the proposed rule. If you have any financial-related questions regarding our comments, please contact Steve Harwell, Director, Economic Analysis, at (518) 431-7777. For clinical and policy questions regarding our comments, please contact Debora LeBarron, Director, Continuing Care, at (518) 431-7702, or at dlebarro@hanys.org.

Sincerely,

Raymond Sweeney
Executive Vice President

RS:do

Submitter : Ms. Marilyn Litka-Klein
Organization : Michigan Health & Hospital Association
Category : Health Care Provider/Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached comment letter regarding the FY 2006 SNF PPS Proposed Rule.

CMS-1282-P-94-Attach-1.DOC



MICHIGAN HEALTH & HOSPITAL ASSOCIATION

Advocating for hospitals and the patients they serve.

Attachment #94

July 12, 2005

Mr. Mark McClellan, M.D., Ph.D.
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 FY 2006.

Dear Administrator McClellan:

On behalf of our 145 member hospitals and other healthcare providers, the Michigan Health & Hospital Association (MHA), appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) regarding the fiscal year 2006 proposed rule on the skilled nursing facility prospective payment system (SNF PPS). In addition to a market basket update, the proposed rule recommends structural changes to the current payment system and a related termination of payment add-ons, which will have a significant impact on SNF providers. It is anticipated that upon incorporation of all proposed changes, SNFs will receive no overall net increase, which is extremely alarming.

As part of the reasoning used to reevaluate the need to remove the temporary payment add-ons and replace them with case-mix refinements, the 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 negative 87 percent.** The report indicated that this might be because "hospitals have higher cost structures than freestanding nursing homes".

While the MHA supports the CMS' efforts to begin implementing fundamental revisions in the SNF PPS case-mix system, we also believe that replacing the add-on payments with case-mix refinements that decrease overall Medicare payments by 3 percent will significantly increase the financial hardship currently experienced by SNFs, especially hospital-based SNFs. In Michigan,

SPENCER JOHNSON, PRESIDENT

CORPORATE HEADQUARTERS ♦ 6215 West St. Joseph Highway ♦ Lansing, Michigan 48917 ♦ (517) 323-3443 ♦ Fax (517) 323-0946
CAPITOL ADVOCACY CENTER ♦ 110 West Michigan Avenue, Suite 1200 ♦ Lansing, Michigan 48933 ♦ (517) 323-3443 ♦ Fax (517) 703-8620
www.mha.org

Mark McClellan, MD, PhD

July 12, 2005

Page 2 of 7

94

Medicare margins have decreased for hospital-based SNFs from negative 37 percent in 2001 to negative 52.5 percent in 2003.

We appreciate the CMS' attempt to more accurately pay for Medicare's sickest SNF patients as the need for such a shift has been endorsed by the Medicare Payment Advisory Commission (MedPAC) for several years. We also appreciate the CMS' recommendation to postpone implementation of these changes until January 1, 2006. This will delay the negative consequences to some SNF providers and enable them to make the necessary operational changes to remain financially viable with less income.

However, we remain concerned that a comprehensive remedy has not yet been developed to correct the fundamental flaw to fully reimburse non-therapy ancillary services. Our primary concern is that under the proposed rule, hospital-based SNFs would continue to be disproportionately harmed until a future comprehensive refinement corrects the underpayment of nontherapy ancillary services.

Congress first expressed its concerns about access for medically complex SNF patients through two legislative measures. First, in the Balance Budget Refinement Act of 1999 (BBRA), Congress authorized a 20 percent increase in the per diem rates for 15 resource utilization groups (RUG), the payment unit for SNFs, 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 four percent.

Next, through the Benefits Improvement and Protection Act of 2000 (BIPA), Congress directed the CMS to study alternative systems for categorizing Medicare SNFs patients according to their relative resource use. In the proposed rule the CMS notes its interpretation of the BIPA mandate for a study: "...we believe that the Congress clearly intended for this study to address comprehensive changes..." BIPA also authorized a temporary add-on of 16.66 percent to be applied to the nursing component of each RUG and reduced the 20 percent add-on to 6.7 percent for selected rehabilitation RUGs.

The CMS has neither released the study called for in BIPA nor proposed a specific remedy addressing the primary cause of access problems for medically complex SNF patients – underpayment of nontherapy ancillary services. Instead, as stated in the proposed rule, the 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, the CMS notes that MedPAC has estimated 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 did not recognize the significantly different financial picture for hospital-based SNFs that have endured dramatically negative Medicare margins.** Although the Congressionally mandated payment

add-ons have not completely offset the fundamental challenges experienced by hospital-based SNFs, they have provided some relief.

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

Due to a severe physician shortage, many nursing homes, primarily ones in distressed urban and remote rural areas, such as the remote areas within Michigan's Upper Peninsula, and the Upper Lower Peninsula, struggle to provide medical services. As a result, 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 residents, improve quality of care and resident outcomes and are essential educational resources for the interdisciplinary care team. Since these areas already have a shortage of qualified providers and rely on NPs and CNSs to provide care it is unclear how the SNF could comply with the proposed requirement without access to additional providers. The MHA strongly disagrees with the 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.

The MHA believes that the CMS' interpretation of 424.20(e)(2) is 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 residents. If physicians in each of these relationships are permitted by the CMS to conduct certification/recertifications without the 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 the CMS' opposing positions on 424.20(e)(1) and 424.20(e)(2) to reflect a double standard. **As a result, the MHA urges the 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 Refinements to the Case-Mix Classification System

The 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

94

would create a new RUG category – Combined Rehabilitation and Extensive Care – which would consist of nine new RUGs. The new category of RUGs would have the highest relative weights within the SNF PPS while other RUG weights would be decreased proportionally. The 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 RUGs categories would be more homogeneous, however the payment system's predictive power would only marginally improve as a result of the new RUGs.

The 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. The 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 the CMS cannot adequately explain these discrepancies within and across RUGs and that the addition of nine new RUGs does not 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. The MHA urges the CMS to add an outlier policy to the SNF PPS to support high cost patients.**

To address the high degree of variability in non-therapy ancillary utilization within and across the RUGs, the 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. The 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. The 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 new 53 RUGs for the SNF PPS would take effect along with the proposed nursing component payment add-on.

We believe the core problem with the current SNF PPS and this proposed rule is the failure to fully reimburse SNFs for nontherapy ancillary services. On average, the higher acuity caseloads in hospital-based SNFs require more nursing time and nontherapy ancillary services than freestanding facilities. Ancillary costs contribute to a large percentage of total Medicare costs for both hospital-based SNFs (32 percent) and freestanding SNFs (38 percent). However, **for hospital-based SNFs, nontherapy ancillaries comprise a much greater proportion of total ancillary costs (57 percent) 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

94

and infrastructure needed to deliver these critical services, such as dialysis, respiratory therapy, IV therapy, laboratory, and radiology.

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 currently the CMS has a very limited ability to address this problem, which resulted in the proposal to apply an across-the-board increase to the nursing component of the RUGs. While this measure to increase aggregate payments is appreciated, it provides additional reimbursement to facilities that do not incur the costs while under-compensating facilities that do incur the costs.

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, the problem of underpayment of nontherapy ancillaries would continue and the overall financial situation would become more challenging since the current \$1.4 billion in payment add-ons would only partially be offset by the proposed across-the-board payment add-on. Until a more targeted and effective remedy is available, SNFs that treat the most complex cases will continue to struggle. More must be done in the interim to assist SNFs treating the sickest Medicare patients. As a result, **the MHA recommends that the CMS implement a hospital-based SNF facility adjustment to support the medical infrastructure needed to care for complex beneficiaries with advanced skilled nursing needs.** Until a broader refinement is available, we strongly believe the CMS should adopt measures such as a hospital-based facility adjustment which would provide relief hospital-based SNFs since they serve a disproportionate share of medically complex patients. 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 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 that 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, on average, have a length of stay (ALOS) that is half that (13 days) 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 due to 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 time of their freestanding counterparts – however many Medicare patients clinically benefit from this more intensive approach. Further

94

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, the **MHA urges the CMS to create an outlier pool equal to 2 percent of SNF payments, which would help minimize access problems for the most costly patients who are difficult to place.** All other prospective payment systems in the Medicare program include an outlier policy and the SNF providers are in desperate need of this additional protection. Funding of the outlier pool should be done in a budget neutral manner.

The 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 larger daily rate for the early days of a stay than the later days. This approach would be a good fit for the SNF PPS since it would acknowledge the higher costs incurred in the early days of a SNF stay. This would provide an incentive for SNFs to treat sicker, short-stay patients and help address the documented problem of limited access to care for these patients.

Extension of AIDS Payment Add-on

The MHA 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 to core-based statistical areas (CBSA) should be phased in based on the same parameters used for the CBSA phase-in for general acute hospitals in FY 2005. This would result in SNFs that would experience a drop in their wage index due to the adoption of the new labor market areas would have their wage index adjustment applied based on a 50-50 blend of the MSA and CBSA adjustment. 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 for three years. This transition should be applied in a budget neutral manner.

Three-day Inpatient Hospital Stay Requirement

While not proposing a specific change to the current policy for counting hospital days to establish eligibility for Medicare coverage in a SNF, the proposed rule seeks 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 coverage in a SNF. In the inpatient setting, observation days count toward the inpatient length of stay if followed by a hospital admission. Patients often receive a full range of services during the observation phase. Therefore, there is no reason to not include observation days in this count. As a result, **the MHA supports counting hospital observation**

Mark McClellan, MD, PhD

July 12, 2005

Page 7 of 7

94

days towards fulfillment of the SNF prior hospitalization requirement, as allowed under current statute.

Thank you for your review and consideration of these comments. If you have any questions, please contact me at (517)703-8603 or via email at mklein@mha.org.

Sincerely,

Marilyn Litka-Klein

Marilyn Litka-Klein
Senior Director, Health Policy

Submitter : Mr. Stephen Reynolds
Organization : Culpeper Health & Rehabilitation Center
Category : Long-term Care

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

In 1993 the United States Office of Management and Budget determined That Culpeper County met the statistical criteria to be included in the Washington DC/Northern Virginia MSA. What has changed? The reality is that the County is now growing at a rate faster than most other in the country. In fact Culpeper county is projected 50 plus% growth by the year 2020. The US Census Bureau published its population estimates of the fastest growing counties in the US. Culpeper County is rated as number 87 out of the top 100 fastest growing counties in the entire country. Most of the population growth is from the Washington DC area. In fact many of the now new occupants that live in Culpeper County work in the Washington area. I now have to pay Washington rates of pay to have staffing to care for these Patients. This cost of living and wages have not decreased in the past ten years so how is it that now CMS can determine that the cost of caring for these patients is cheaper today? Do you truly realize the negative impact that your decision to restructure these rates will have on the quality of life that which you hold authority to govern? Is this right thinking towards the most vulnerable population of our nation?

Issue

Case-Mix Adjustment and Other Clinical Issues

Clinical care needs continue to grow in demand. The co-morbidities are higher than ever and as the baby boomer generation come into the health care demand the county will see a tremendous increase in clinical needs of this population. The cost is not going down rather will increase tremendously as the shortage of RN's alone will double each five year increments.

Submitter : Laurence Lane
Organization : Genesis HealthCare Corporation
Category : Long-term Care

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

Incorporating the revisions proposed in the rules and following the grouper instructions posted on the CMS website, we are disappointed to find that when the RUG refinements are implemented on January 1, 2006, for our portfolio of skilled nursing facilities and beneficiary case mix, the impact could be as much as a 7% reduction from our current FY05 average per patient diems. When analyzed on a facility-by-facility basis, Genesis will have skilled nursing facilities that will experience rate reductions of more than 15% - over \$60 ppd. Reductions in revenues of these magnitudes will significantly strain our resources and certainly impact our efforts to upgrade our buildings and improve clinical services. For certain, we will be forced to evaluate whether it makes economic sense to continue to operate several facilities under the pernicious conditions of the proposed rules. We struggle to reconcile these financial estimates with the optimistic public relations positioning in the CMS press statement announcing the proposed rules.

While we strongly support moving forward to address the underlying flaws of the original SNF PPS methodology that failed to recognize the costs incurred by facilities for non-therapy ancillaries, we are concerned that the proposed rules will have a more negative impact on SNF services than anticipated by CMS. Just as the modeling that supported the original implementation of SNF PPS in 1998 was flawed resulting in the dramatic miscalculation of impact, we fear many of these same errors are embedded in the analysis supporting these rules.

Issue

Issue

1. Anomalies in Re-weighting will impact Clinical Resources:
 (Reference: Case Mix Adjustment and Other Clinical Issues)

Even with the new data posted on the CMS web-site on June 26, we struggle to understand the algorithms used to re-weight the revised RUG classifications. Over the past seven years, since the inception of the SNF PPS system, CMS has consistently articulated the rationale for the assignment of resources to the rehabilitation categories and the agency has accepted criticisms that the weakness in the current system lies in the funding for non-therapy ancillaries. In fact, CMS points out on page 29076 of the proposed rules, "our research findings show little or no correlation between the groups within the Extensive Services categories and the level of rehabilitation services used. For this reason, the structure for this new hierarchy level would closely mirror that of the existing Rehabilitation Therapy groups." Yet, the proposed re-weighting disproportionately changes the calculations (both nursing and rehab), without explanation, for several of the higher utilized rehab categories (RVC, RVB, RHC, RHB, RHA). These categories account for nearly 50% of Medicare SNF days in our facilities and the reduction on allocated resources explain (post-RUG 53 regrouping) a significant portion of the revised rate impact. The re-weighting appears to be premised on preserving the hierarchical purity of the RUG system and pre-determined budget-defined outcomes than on meeting the clinical needs of beneficiaries.

Recommendations:

- ?< CMS must be more transparent in its decisions and release all data supporting these rules; the agency has neither released the complete analyses performed by the Urban Institute nor has it transmitted to Congress the required report documenting its findings on addressing the under-funding of non-therapy ancillaries.
- ?< CMS should verify that the conversion errors corrected in its errata sheet posted on May 26, 2005, were not embedded in the modeling supporting the re-weighting.
- ?< Acknowledging that the staff time measurement studies (STMs) are significantly outdated and are neither reflective of today's staffing patterns and/or compensation relationships, CMS must increase the nursing and rehab weighted index by a factor of at least 5%.

Wage Index Data

4. CMS Must Update and Rebase the CMS SNF Market Basket:
 (Reference: SNF Market Basket Index)

The SNF market basket factor is defective and continues to understate compensation, pharmacy and operating costs. Current major basket weights are based on PPS data (1997 base year) and do not reflect changing staffing, higher pharmacy costs and rising liability insurance costs. Considerable attention is given in both the Alliance and AHCA comments on these proposed rules to the defects in the current CMS SNF Market Basket and the need for CMS to make necessary corrections. We are most appreciative of the considerations given by the agency during the FY04 rule-making correcting the market basket for identified forecast errors. While this adjustment helped, it did not correct the underlying flaws of an outdated index. CMS's own Report to Congress on the Appropriateness of Minimum Staffing Ratios in Nursing Homes offer of anthology of data affirming that care patterns have changed and compensation for caregivers have changed since the last major revision to the market basket. Moreover, the current market basket fails to adequately address the relative importance of pharmaceutical and liability insurance costs.

Recommendation:

- ?< Implement an adjustment to the market basket to correct for the inherent weaknesses of the current formula to appropriately compensate for changing staffing, higher pharmacy costs and rising liability insurance costs.

Proposed Refinements to the Case-Mix Classification System

5. CMS should make no changes to the MDS Instructions that will alter RUG classification:

(Reference: Case Mix Adjustment and Other Clinical Issues)

(Reference: Concurrent Therapy)

In the proposed rule preamble, CMS invites comments on a number of revisions to MDS instructions and solicits comments on several clinical issues. We believe the agency has a tendency to minimize the impact of tinkering with the MDS patient assessment requirements. Time studies and staffing requirements are the fundamental building blocks of the SNF PPS methodology. Changing the assessment rules without measuring their impact on resource allocations undermines the foundation of the payment system. Our modeling of the proposed RUG refinements (and that of CMS, the Urban Institute, Lewin Group, and Muse and Associates) is premised on the rules staying the same. Eliminating the "lookback" would significantly decrease the number of patients qualifying for Extensive Care. Any elimination of the "lookback" would require a redistribution of resources back to the existing 14 Rehab levels as the volume of patients moving into the 9 new categories would be significantly less. Likewise, changes in the application of MDS instructions for calculating therapy minutes and for applying therapy services would significantly alter the basic ground rules for proper RUG placements. The "five day assessment" drives the payment structure for the first 14 days. The option of using "grace days" assures an accurate accounting for delivered therapy services; alternatively facilities have the option to forecast therapy minutes. Both options are important to assure facilities are appropriately reimbursed for services rendered, and/or expected to be delivered. We also note that CMS once again asserts that some skilled nursing facilities are engaging in questionable therapy deliver practices. Given the stringent state practice acts governing each of the therapy disciplines and the broad ranging medical review authority already being exercised by Federal contractors, it is unnecessary for CMS to use these payment rules as the vehicle for additional guidance. It should be noted that if CMS were to make changes that alter the operational practices in place when the staff time management measures (STMs) were taken, that the agency would have to revise its resource measures to compensate for the required clinical activity.

Recommendation:

< CMS must provide assurances that changes in patient assessment rules will not be implemented until their impact on resource utilization measures are tested and validated.

Case-Mix Adjustment and Other Clinical Issues

5. CMS should make no changes to the MDS Instructions that will alter RUG classification:

(Reference: Case Mix Adjustment and Other Clinical Issues)

(Reference: Concurrent Therapy)

In the proposed rule preamble, CMS invites comments on a number of revisions to MDS instructions and solicits comments on several clinical issues. We believe the agency has a tendency to minimize the impact of tinkering with the MDS patient assessment requirements. Time studies and staffing requirements are the fundamental building blocks of the SNF PPS methodology. Changing the assessment rules without measuring their impact on resource allocations undermines the foundation of the payment system. Our modeling of the proposed RUG refinements (and that of CMS, the Urban Institute, Lewin Group, and Muse and Associates) is premised on the rules staying the same. Eliminating the "lookback" would require a redistribution of resources back to the existing 14 Rehab levels as the volume of patients moving into the 9 new categories would be significantly less. Likewise, changes in the application of MDS instructions for calculating therapy minutes and for applying therapy services would significantly alter the basic ground rules for proper RUG placements. The "five day assessment" drives the payment structure for the first 14 days. The option of using "grace days" assures an accurate accounting for delivered therapy services; alternatively facilities have the option to forecast therapy minutes. Both options are important to assure facilities are appropriately reimbursed for services rendered, and/or expected to be delivered. We also note that CMS once again asserts that some skilled nursing facilities are engaging in questionable therapy deliver practices. Given the stringent state practice acts governing each of the therapy disciplines and the broad ranging medical review authority already being exercised by Federal contractors, it is unnecessary for CMS to use these payment rules as the vehicle for additional guidance. It should be noted that if CMS were to make changes that alter the operational practices in place when the staff time management measures (STMs) were taken, that the agency would have to revise its resource measures to compensate for the required clinical activity.

Recommendation:

< CMS must provide assurances that changes in patient assessment rules will not be implemented until their impact on resource utilization measures are tested and validated.

Case-Mix Adjustment and Other Clinical Issues

2. Revisions Fail to adequately resolve Funding for Non-Therapy Ancillaries:

(Reference: Proposed Refinements to the Case-Mix Classification System)

CMS has proposed a useful framework adding new payment categories for those residents requiring both rehabilitation and medically complex services. While supportive of this step, we are concerned that the core issue, i.e., the adequate funding for non-therapy ancillaries, is not resolved by what CMS is proposing. Analyses performed by the Lewin Group that replicate the Urban Institute and Abt Studies document that the proposed revisions do not significantly alter the very weak cost/resources correlations for the RUG system and they do very little to correct the historic non-recognition of non-therapy ancillaries in the SNF PPS payment system. In short, we confront the political decision to wink-and-nod at a proposed restructuring that resolves the year-to-year battles over RUG add-ons but does not adequately resolve the funding for non-therapy ancillaries. A strong legal case has been presented to CMS that RUG refinements do not need to be budget neutral.

Recommendations:

< CMS must increase its nursing weight adjustment upward, at least by 8%, to fully reflect changes in the acuity of nursing facility residents and to adequately

compensate for non-therapy ancillaries.

?< CMS should redistribute the case mix adjustment to RUG categories with the highest utilization of non-therapy ancillaries thus improving the targeting of resources.

Proposed Revisions to the SNF PPS Labor Market Areas

3. Geographic Reclassification Distorts Payment Levels:

(Reference: Proposed Revisions of SNF PPS Labor Market Areas)

We struggle with the CMS rationale for moving forward with the proposed geographic reclassification. Accepting that the proposed policy changes are driven by a well-intentioned effort to assure the accurate allocation of resources, the results are most disruptive. We are a major SNF provider in New Jersey operating 28 skilled centers. When we isolate the variables that explain per diem rate changes in these centers, revisions in the geographic classifications jump out as significant. Several of our facilities shift from urban to suburban, (proposed !?micropolitan areas!? reclassification). The negative PPD rate impact exceeds 5% in seven of these centers; three centers have rate changes of more than \$50 ppd. In New Hampshire, we have 10 skilled nursing centers. Seven of these centers will experience negative rates in excess of \$30 PPD. These changes are driven by the new calculations for rural facilities. While these geographic changes basically average out across our complete portfolio of SNF services, there is a clear pattern that urban facilities are generally advantaged; suburban and rural facilities are seriously disadvantaged.

Recommendations:

?< Delay introduction of the new geographic reclassifications until defects in the current law to give SNFs the opportunities to secure market reclassifications and to have !?rural floors!? are enacted.

?< If the decision is made to move forward with geographic reclassification, phase it in following the guidance set forth in the Alliance/AHCA response to these rules

CMS-1282-P-96-Attach-1.DOC

CMS-1282-P-96-Attach-2.DOC

CMS-1282-P-96-Attach-3.DOC

July 11, 2005

Mark B. McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 309-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Attention: CMS-1282-P

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006; Proposed Rules

On behalf of Genesis HealthCare Corporation, a leading provider of healthcare and support services to the elderly, I write commenting on the proposed SNF prospective payment rules published in the Federal Register, May 19, 2005 (Vol. 70, No. 96).

Genesis HealthCare Corporation owns/operates approximately 23,000 skilled nursing facility certified beds in twelve states stretching from North Carolina/West Virginia through New Hampshire and Vermont. We provide over a million days of Medicare SNF services, about 2% of total annual Medicare SNF covered days.

Leaders from our company have participated in the drafting of the extensive comments on these proposed rules that will be submitted by both the Alliance for Quality Nursing Home Care (Alliance) and the American Health Care Association (AHCA). We have also assisted in the drafting of comments being prepared by the National Association for the Support of Long Term Care (NASL). Rather than duplicate these detailed comments, I will narrow the focus of this correspondence to reinforce key recommendations and offer an assessment of the proposed rules from the perspective of the nearly 200 skilled nursing facilities operated by GHC.

I. General Assessment: Positive Policy Framework – Insufficient Resources:

These complex proposed rules make **five major changes**: (i) CMS proposed changes in the payment classification system implementing “RUG refinements” – adding 9 new payment categories to the existing 44 Resource Utilization Groups (RUGs); (ii) CMS proposes a “budget neutral” implementation of these changes, adjusting the payment weights for current payment categories to accommodate the expected utilization of the new payment groups; (iii) CMS proposes an 8.85% upward “case-mix” adjustment of the nursing weights for all RUG categories

to reflect changes in SNF acuity and to address funding for non-therapy ancillaries; (iv) CMS proposes changes in the labor markets designations; and, (v) CMS proposes a full market basket increase for FY06 rates which is more than offset by the loss of the BIPA funding of certain RUG add-ons. In addition, the preamble to the rules solicits input on a number of potential policy changes including altering patient assessments rules and other payment reforms.

Incorporating the revisions proposed in the rules and following the grouper instructions posted on the CMS website, **we are disappointed to find that when the RUG refinements are implemented on January 1, 2006, for our portfolio of skilled nursing facilities and beneficiary case mix, the impact could be as much as a 7% reduction from our current FY05 average per patient diems. When analyzed on a facility-by-facility basis, Genesis will have skilled nursing facilities that will experience rate reductions of more than 15% - over \$60 ppd. Reductions in revenues of these magnitudes will significantly strain our resources and certainly impact our efforts to upgrade our buildings and improve clinical services. For certain, we will be forced to evaluate whether it makes economic sense to continue to operate several facilities under the pernicious conditions of the proposed rules.** We struggle to reconcile these financial estimates with the optimistic public relations positioning in the CMS press statement announcing the proposed rules.

While we strongly support moving forward to address the underlying flaws of the original SNF PPS methodology that failed to recognize the costs incurred by facilities for non-therapy ancillaries, we are concerned that the proposed rules will have a more negative impact on SNF services than anticipated by CMS. Just as the modeling that supported the original implementation of SNF PPS in 1998 was flawed resulting in the dramatic miscalculation of impact, we fear many of these same errors are embedded in the analysis supporting these rules.

II. Factors Explaining the Negative Impact of the Proposed Rules:

The Genesis team has spent many hours attempting to fully understand our financial projections under the proposed rules. In this endeavor, we have worked cooperatively with the data support teams from other companies and with the outside experts assisting the trade organizations (Alliance and AHCA). Our findings parallel the findings documented in the professional comments being submitted by these trade groups:

- CMS is taking more dollars out of the SNF Payment System than projected.
- There are unexplained anomalies in the conversion to RUG 53 resulting in errors in both the nursing and rehab weights with the resulting shortchanging of providers.
- Half of the resources necessary to support non-therapy ancillaries are withdrawn, and the half that is retained is not built adequately into future base payments with the resulting under reimbursement for such services in future year payments.
- The adjustment factor added to the nursing component of the case-mix weights is inadequate to compensate for non-therapy ancillaries and related care needs.
- The CMS simulations of beneficiaries qualifying for the refined 53-group RUG classification system are premised on no changes to the MDS Manual instructions; in fact, because the Standard Time Measurement studies (STM) are based on identical observation period rules, any significant changes in interpretation of MDS instructions undermine the reliability of the data supporting the SNF PPS payment system;

- The sample used to develop the CMS projections of beneficiaries qualifying for the new nine RUG classification groups is skewed towards hospital-based facilities, with the resulting over-estimate of utilization of these payment categories and the resulting reduction of resources necessary to adequately support the current RUG 44 categories (accepting the assumption of budget-neutrality).
- The proposed revision of SNF PPS geographic classifications significantly distorts payment levels, especially for rural and suburban areas.
- Historic flaws in the SNF market basket continue to suppress the accurate reflection of SNF costs changes; year-to-year understatement of incurred costs inappropriately suppresses SNF PPS rates.

III. Addressing the Most Glaring Problems:

Most, if not all of these issues identified in Section II are discussed in extensive details in the comments being submitted by the Alliance and AHCA. Both of these professional presentations will include specific recommendations addressing each of the issues. Rather than to repeat these concerns and recommendations, I will highlight the several areas where our data affirm the proposed changes that have the most negative impact on Genesis HealthCare facilities:

1. Anomalies in Re-weighting will impact Clinical Resources: (Reference: Case Mix Adjustment and Other Clinical Issues)

Even with the new data posted on the CMS web-site on June 26, we struggle to understand the algorithms used to re-weight the revised RUG classifications. Over the past seven years, since the inception of the SNF PPS system, CMS has consistently articulated the rationale for the assignment of resources to the rehabilitation categories and the agency has accepted criticisms that the weakness in the current system lies in the funding for non-therapy ancillaries. In fact, CMS points out on page 29076 of the proposed rules, "our research findings show little or no correlation between the groups within the Extensive Services categories and the level of rehabilitation services used. For this reason, the structure for this new hierarchy level would closely mirror that of the existing Rehabilitation Therapy groups." Yet, the proposed re-weighting disproportionately changes the calculations (both nursing and rehab), without explanation, for several of the higher utilized rehab categories (RVC, RVB, RHC, RHB, RHA). These categories account for nearly 50% of Medicare SNF days in our facilities and the reduction on allocated resources explain (post-RUG 53 regrouping) a significant portion of the revised rate impact. The re-weighting appears to be premised on preserving the hierarchical purity of the RUG system and pre-determined budget-defined outcomes than on meeting the clinical needs of beneficiaries.

Recommendations:

- ***CMS must be more transparent in its decisions and release all data supporting these rules; the agency has neither released the complete analyses performed by the Urban Institute nor has it transmitted to Congress the required report documenting its findings on addressing the under-funding of non-therapy ancillaries.***
- ***CMS should verify that the conversion errors corrected in its errata sheet posted on May 26, 2005, were not embedded in the modeling supporting the re-weighting.***

- *Acknowledging that the staff time measurement studies (STMs) are significantly outdated and are neither reflective of today's staffing patterns and/or compensation relationships, CMS must increase the nursing and rehab weighted index by a factor of at least 5%.*

**2. Revisions Fail to adequately resolve Funding for Non-Therapy Ancillaries:
(Reference: Proposed Refinements to the Case-Mix Classification System)**

CMS has proposed a useful framework adding new payment categories for those residents requiring both rehabilitation and medically complex services. While supportive of this step, we are concerned that the core issue, i.e., the adequate funding for non-therapy ancillaries, is not resolved by what CMS is proposing. Analyses performed by the Lewin Group that replicate the Urban Institute and Abt Studies document that the proposed revisions do not significantly alter the very weak cost/resources correlations for the RUG system and they do very little to correct the historic non-recognition of non-therapy ancillaries in the SNF PPS payment system. In short, we confront the political decision to wink-and-nod at a proposed restructuring that resolves the year-to-year battles over RUG add-ons but does not adequately resolve the funding for non-therapy ancillaries. A strong legal case has been presented to CMS that RUG refinements do not need to be budget neutral.

Recommendations:

- *CMS must increase its nursing weight adjustment upward, at least by 8%, to fully reflect changes in the acuity of nursing facility residents and to adequately compensate for non-therapy ancillaries.*
- *CMS should redistribute the case mix adjustment to RUG categories with the highest utilization of non-therapy ancillaries thus improving the targeting of resources.*

**3. Geographic Reclassification Distorts Payment Levels:
(Reference: Proposed Revisions of SNF PPS Labor Market Areas)**

We struggle with the CMS rationale for moving forward with the proposed geographic reclassification. Accepting that the proposed policy changes are driven by a well-intentioned effort to assure the accurate allocation of resources, the results are most disruptive. We are a major SNF provider in New Jersey operating 28 skilled centers. When we isolate the variables that explain per diem rate changes in these centers, revisions in the geographic classifications jump out as significant. Several of our facilities shift from urban to suburban, (proposed "micropolitan areas" reclassification). The negative PPD rate impact exceeds 5% in seven of these centers; three centers have rate changes of more than \$50 ppd. In New Hampshire, we have 10 skilled nursing centers. Seven of these centers will experience negative rates in excess of \$30 PPD. These changes are driven by the new calculations for rural facilities. While these geographic changes basically average out across our complete portfolio of SNF services, there is a clear pattern that urban facilities are generally advantaged; suburban and rural facilities are seriously disadvantaged.

Recommendations:

- *Delay introduction of the new geographic reclassifications until defects in the current law to give SNFs the opportunities to secure market reclassifications and to have “rural floors” are enacted.*
- *If the decision is made to move forward with geographic reclassification, phase it in following the guidance set forth in the Alliance/AHCA response to these rules*

4. CMS Must Update and Rebase the CMS SNF Market Basket:
(Reference: SNF Market Basket Index)

The SNF market basket factor is defective and continues to understate compensation, pharmacy and operating costs. Current major basket weights are based on pre-PPS data (1997 base year) and do not reflect changing staffing, higher pharmacy costs and rising liability insurance costs. Considerable attention is given in both the Alliance and AHCA comments on these proposed rules to the defects in the current CMS SNF Market Basket and the need for CMS to make necessary corrections. We are most appreciative of the considerations given by the agency during the FY04 rule-making correcting the market basket for identified forecast errors. While this adjustment helped, it did not correct the underlying flaws of an outdated index. CMS’s own Report to Congress on the Appropriateness of Minimum Staffing Ratios in Nursing Homes offer an anthology of data affirming that care patterns have changed and compensation for caregivers have changed since the last major revision to the market basket. Moreover, the current market basket fails to adequately address the relative importance of pharmaceutical and liability insurance costs.

Recommendation:

- *Implement an adjustment to the market basket to correct for the inherent weaknesses of the current formula to appropriately compensate for changing staffing, higher pharmacy costs and rising liability insurance costs.*

5. CMS should make no changes to the MDS Instructions that will alter RUG classification:
(Reference: Case Mix Adjustment and Other Clinical Issues)
(Reference: Concurrent Therapy)

In the proposed rule preamble, CMS invites comments on a number of revisions to MDS instructions and solicits comments on several clinical issues. We believe the agency has a tendency to minimize the impact of tinkering with the MDS patient assessment requirements. Time studies and staffing requirements are the fundamental building blocks of the SNF PPS methodology. Changing the assessment rules without measuring their impact on resource allocations undermines the foundation of the payment system. Our modeling of the proposed RUG refinements (and that of CMS, the Urban Institute, Lewin Group, and Muse and Associates) is premised on the rules staying the same. Eliminating the “lookback” would significantly decrease the number of patients qualifying for Extensive Care. Any elimination of the “lookback” would require a redistribution of resources back to the existing 14 Rehab levels as the volume of

patients moving into the 9 new categories would be significantly less. Likewise, changes in the application of MDS instructions for calculating therapy minutes and for applying therapy services would significantly alter the basic ground rules for proper RUG placements. The “five day assessment” drives the payment structure for the first 14 days. The option of using “grace days” assures an accurate accounting for delivered therapy services; alternatively facilities have the option to forecast therapy minutes. Both options are important to assure facilities are appropriately reimbursed for services rendered, and/or expected to be delivered. We also note that CMS once again asserts that some skilled nursing facilities are engaging in questionable therapy deliver practices. Given the stringent state practice acts governing each of the therapy disciplines and the broad ranging medical review authority already being exercised by Federal contractors, it is unnecessary for CMS to use these payment rules as the vehicle for additional guidance. It should be noted that if CMS were to make changes that alter the operational practices in place when the staff time management measures (STMs) were taken, that the agency would have to revise its resource measures to compensate for the required clinical activity.

Recommendation:

- ***CMS must provide assurances that changes in patient assessment rules will not be implemented until their impact on resource utilization measures are tested and validated.***

**6. CMS should eliminate Site of Service as Consolidated Billing criteria:
(Reference: Consolidated Billing)**

Our skilled nursing facilities have been economically disadvantaged by the rigid interpretation maintained by CMS that excluded services can only be purchased from hospital-based entities. In many locations, especially rural settings in West Virginia, Vermont, New Hampshire, Pennsylvania, our facilities are at a disadvantage in competitively securing clinically necessary services for beneficiaries. Under the current interpretation, if the facility secure services from other than a hospital-based setting, the services are defined as part of the bundle of consolidated services but if secured from a hospital-based setting the item/service is excluded.

Recommendation:

- ***CMS should remove site-of-service as a criteria for whether or not a service is included/excluded in consolidated billing.***

IV. Summary:

Because of the funding crisis caused by the Balanced Budget Act of 1997 and the subsequent fiscal turmoil which caused many investor-owned skilled nursing facilities, including our predecessor company Genesis Health Ventures, into bankruptcy, facility maintenance and physical plant improvements have suffered. This year, the Genesis HealthCare Corporation Board of Directors voted to commit up to \$75 million per year for the next three years in a multi-year funding program for capital improvements for our 200+ eldercare facilities. We fully recognize that the average age of our physical plants is 27 years; and that a third of our portfolio of owned

and operated properties is more than 40 years of age. **Adequate, stable and predictable funding is essential if government is to interest investors in investing in services that will be necessary for the coming generation of elderly and disabled.**

Under the proposed rules, future Medicare skilled nursing facility per diems are reduced by more than 5%. For Genesis Healthcare Facilities, the impacts of the proposed rule appears to be even more negative comparing our current FY05 rates and the payment levels that will be in place once RUG refinements are implemented in Q2, FY06. **For us, and for the skilled nursing sector at large, continuing to provide quality care and upgrade our services under the requirements of the proposed rules will be challenging.**

Public programs purchase care and services for 85% of our residents **Nursing homes confront a double whammy – Medicare SNF cuts and state Medicaid rate containment.** The compound effect of reduced Medicare payments and reductions in Medicaid funding could once again bring the sector to the brink of fiscal instability. While supportive of the proposed RUG refinements, we do not believe CMS has been forthcoming in examining the impact of these lost resources on beneficiary services. To the extent that reduced reimbursement impedes investments in clinical and facility improvements, government is putting our abilities to meet future needs at jeopardy.

We urge CMS to listen to the concerns of the provider community and to accept our recommendations for strengthening the proposed refinement. Quality care will only occur when we have the resources necessary to attract, train and retain direct care providers. As written, the proposed rules shortchange us on those necessary resources; and in doing so, undermines the integrity of the prospective payment system.

Sincerely,

George V. Hager, Jr.
Chairman and CEO

Submitter : Mrs. Elizabeth Cole
Organization : Newman Regional Health
Category : Hospital

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

No file attached

Submitter : Mr. Ron Burgin
Organization : Cahaba Safeguard Administrators - PSC for NC Pt A
Category : Federal Government

Date: 07/12/2005

Issue Areas/Comments

Issue

Concurrent Therapy

Comments relating to:
 FILE CODE: CMS-1282-P

Section II B 7- Concurrent Therapy

The North Carolina Medicare Part A PSC, Cahaba Safeguard Administrators, LLC (CSA), performed a number of onsite reviews of Skilled Nursing Facilities (SNF) within the last several months and had the opportunity to see ?concurrent therapy? in action. The facilities chosen for onsite visits were selected through data analysis of the billing of inpatient SNF claims in the State of North Carolina.

We observed ?concurrent therapy? being delivered as the primary therapy for most of the patients in many of these facilities. We found that the therapy staff in each facility billed up to 10 or 12 hours of therapy per day, per therapist, while the hours that an individual therapist actually provided services ranged from between four to six hours. All of the time counted for each beneficiary while in therapy was considered ?concurrent therapy?.

The following is an example of what was observed.

A patient is brought to the therapy room at 10:00 am. He works with the therapist one-on-one for 10 minutes. A second patient is brought into the room at 10:10. The therapist begins working with the new patient one-on-one for 10 minutes. The first patient, in the meantime, is ?resting?. At 10:20, a third patient is brought into the room and begins to work with the therapist. The first and second patients, meanwhile, are resting. At 10:30, the therapist begins to work again with the first patient for 5 to 10 minutes, moves on to the second patient, then the third patient. At 10:55, the first patient works with the therapist for a brief time (5 minutes), and is then taken back to his room. A new patient is brought in and the cycle continues.

In the above scenario, each individual received about 20 to 30 minutes of therapy and the provider counted the time as 60 minutes of ?concurrent therapy?. We also observed that part of the therapy time often might involve sitting with an applied hot or cold pack.

Below is an example we observed involving occupational therapy.

One patient starts stringing beads, while another is putting pegs into a board, and a third is buttoning a shirt. Once again, the time is counted from the time that the patient enters the therapy room to the time that they are returned to their room. Often, when the therapist turns away, the patient stops the activities until the therapist looks back at them. None of the activities performed by the patients during this ?concurrent therapy? session appeared to require the skills of a therapist.

In the facilities we visited, the majority of claims for these patients involved RU and RV RUG codes.

There is a concern that ?concurrent therapy? is being used as the treatment of choice for all patients in certain facilities in order to maximize payments. It does not appear that the types of services provided in these facilities are individualized services of such a complexity that they require the skills of a therapist.

If concurrent therapy were going to continue to be covered, it would be useful if clear guidelines were established. For instance, how many patients can be treated in this manner at the same time? Can two, three, or four patients be treated together under the supervision of a therapist? Can assistants provide concurrent therapy as well as licensed therapist? Should the plan of treatment specify what specific activities could be done as concurrent therapy? Is it ever reasonable for a patient's entire therapy to be done as concurrent therapy?

Submitter : Ms. Melissa Dehoff
Organization : The Hospital & Healthsystem Assoc. of Pa
Category : Health Care Professional or Association

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-1282-P-99-Attach-1.DOC



THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

July 12, 2005

Mark McClellan, M.D., Ph.D.
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 FY 2006; (70 *Federal Register* 96, May 19, 2005)

Dear Dr. McClellan:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 250 member institutions, including 125 stand-alone hospitals and another 120 hospitals that comprise 32 health systems across the state, we appreciate this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2006 proposed rule on the skilled nursing facility (SNF) prospective payment system (SNF PPS). Our comments focus on the major provisions of this proposed rule, which include: Case-Mix Refinements; MDS Revisions; SNF Certifications and Re-Certifications; Revisions to SNF PPS labor market areas; and the requirement surrounding the qualifying three-day inpatient hospital stay.

Hospital-based SNFs

Hospital-based SNFs provide a very different model of care than freestanding SNFs due to treating sicker patients and the scope and intensity of the services provided is more advanced, thus proving to be more costly. Both the SNF PPS per diem structure and its underpayment of non-therapy ancillary services impose significant disadvantages on hospital-based SNFs treating sicker patients that require more extensive services during a concentrated period. Hospital-based SNFs have an average length of stay (ALOS) that is half (13 days) that of freestanding facilities (27 days). While the average per diem cost for hospital-based SNF patients is higher than for patients in freestanding facilities due to the 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. Measures are needed to enable hospital-based SNFs to continue delivering care using this clinically valuable model without a financial penalty. To sustain this distinct model of care, HAP urges CMS to create an outlier policy equal to two percent of SNF payments. This outlier policy would help minimize access problems for the most costly patients who are often difficult to place. All other prospective payment systems in the Medicare

44

program include an outlier policy; the SNF PPS is in need of this additional protection as well.

Due to the complexity of the patients within hospital-based SNFs, the staff employed are highly skilled to ensure a more advanced clinical capacity. These SNFs have a higher staffing ratio per bed than freestanding facilities, and use more registered nurses and licensed practical nurses in their mix of staff per patient bed. Freestanding facilities use more aides in their staff mix per patient bed. HAP recommends the implementation of a hospital-based SNF facility adjustment to support the medical infrastructure needed to care for beneficiaries in need of this advanced skilled nursing. This adjustment would recognize the costly staff, equipment, etc. that must be maintained to provide proper care for these medically complex patients.

The hospital-based SNFs have been disproportionately harmed by the SNF PPS due to its under-reimbursement of non-therapy ancillary services. Non-therapy 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 non-therapy ancillary services harms hospital-based SNFs to a greater degree. Since the implementation of the PPS, the Medicare margins for hospital-based SNFs have declined despite temporary financial add-ons and a shorter patient length of stay. As a result, these unsustainable losses have forced many hospital-based SNFs to close and continue to close if action is not taken to cover the cost of treating these medically complex patients.

The proposed rule does not recognize the significantly different financial picture for hospital-based SNFs, which have endured dramatically negative Medicare margins.

Proposed Refinements to the Case-Mix System

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

The first component of the case-mix refinement proposed is the addition of nine Resource Utilization Group (RUG) categories to better account for the medical complexity of certain residents in the Rehabilitation categories who also have conditions that would otherwise place them in the Extensive Services category. This proposed new RUG category, Combined Rehabilitation and Extensive Care, would have the highest relative weights within the SNF PPS while other RUG weights would be decreased proportionally. HAP supports the proposed increase to 53 RUG groups and the subsequent case-mix index re-weighting.

The second component is an 8.4 percent add-on to the nursing component of the case-mix weights for all 53 RUG categories. This results in a 3 percent increase in overall

99

payment, and is intended to better account for the non-therapy ancillary costs. While HAP supports the effort to rectify the deficiency in the SNF PPS case-mix system, we disagree with the process used to derive the add-on, which was based on an analysis of the Inpatient Rehabilitation Facility (IRF) PPS outlier policy. There is no direct correlation between the IRF outlier costs and SNF non-ancillary costs. In addition, while this measure to increase aggregate payments is a positive move, it would not fundamentally improve the ability of the payment system to predict which patients, within and across payment categories, are most likely to use high-cost non-therapy ancillary services.

AIDS Payment Add-On

HAP strongly supports CMS' proposal to extend the 128 percent add-on payment for AIDS patients. This extension will ensure this patient population will have access to SNF care.

Revision to the Fourteen Day "Look-Back" Provision

CMS analyzed the Minimum Data Set (MDS) focusing on four items in the Special Services section that classify residents into the Extensive Care RUGs category and 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 residents 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 proposing to revise the *MDS Manual* instructions to include only those special care services furnished after a SNF admission or re-admission.

HAP feels a look-back provision of some type must be maintained in the SNF PPS process due to the residual impact of acute care services on the resident and the costs of care in nursing facilities for the first few days post admission.

Newly admitted residents from acute care continue to be transferred to nursing facilities with significant medically complex needs and in fragile clinical condition. The first post-admission days in long-term care are an intense period of adjustment for both staff and resident. Staff gather detailed information about the resident's prior stay, the treatment they have received, and monitoring the resident's response/residual effects to that treatment, as well as evaluating the resident's response to transfer to the nursing facility. These activities are intensive, and are critical to determining an appropriate initial plan of care for the resident 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 resident 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, HAP supports that. However, until such time a study is done, HAP does not support any proposed change to the current look-back provision

Elimination of Grace Days for Five-Day PPS 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.

HAP feels that these grace days should not be eliminated, and thereby remain 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 resident's stay post-admission from the acute care setting are an intense period of information gathering, assessment, care planning and monitoring of the resident, 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 Re-certifications

HAP disagrees with CMS' proposed prohibition of nurse practitioners (NP) and clinical nurse specialists (CNS) to certify/re-certify SNF care based on a presumed conflict of interest for those professionals with an "indirect employment relationship" with the facility. Many nursing facilities struggle to provide medical services due to a severe shortage of physicians, especially in distressed urban and rural areas. The use of NPs and CNSs has become critical to maintaining adequate and competent healthcare coverage in facilities. Studies have shown improved quality of care and resident outcomes in facilities that use NPs and CRNPs. These professionals are also essential educational resources for the interdisciplinary care team.

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 residents. If physicians in each of these relationships are permitted by CMS to conduct certification/re-certifications 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.

94

HAP 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 (CBSA). This change had a significant re-distributional impact, as many areas experienced 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 percent of the wage index based on the new definitions and 50 percent based on the old definitions. CMS proposes to end this protection and determine 100 percent 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. HAP urges 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 and should be applied in a budget-neutral manner.

Qualifying Three-Day Inpatient Hospital Stay Requirement

HAP commends CMS for counting hospital observation days towards the fulfillment of the SNF prior hospitalization requirement, as allowed under current statute. As CMS observes in the proposed rule, the acute care length of stay has decreased since implementation of the SNF PPS and new acute care services has been developed. HAP 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 to nursing homes more appropriately.

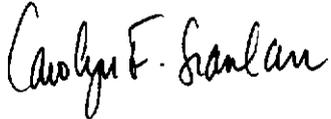
Mark McClellan, MD, Ph.D.
July 12, 2005
Page 6

99

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

HAP appreciates the opportunity to submit these comments on the proposed rule. If you have any questions about our comments, please contact Melissa Dehoff, director, health care continuum finance policy, at (717) 561-5318, or by email at mdehoff@haponline.org.

Sincerely,



CAROLYN F. SCANLAN
President and Chief Executive Officer

CFS/dd

Submitter : Ms. Pauline Franko
Organization : Encompass Consulting & Education, LLC
Category : Physical Therapist

Date: 07/12/2005

Issue Areas/Comments

Issue

Concurrent Therapy

I am a Physical Therapist and, for the last 6 years, have taught seminars to therapists on Medicare. I also write a column answering Medicare questions for a nationwide therapy publication. During this time I have received many questions about Part A services and have heard a lot of the complaints of therapists on this topic.

I receive numerous letters from concerned therapists who are required by management to see anywhere from 4 to 7 patients an hour. There is also the encouragement by management to perform "group" therapy to increase productivity. I personally believe that this is a significant problem, especially when therapists are on a visa or for the assistants that provide a significant amount of the facility care.

My recommendation is that CMS clearly define what it considers concurrent therapy or dovetailing. Presently, the regulations are vague with a presumption, maybe!!!!, that it is referring to 2 patients at the same time. This is not how it is being interpreted by some companies. Concurrent can be any number, sometimes as many as 4 at a time, counting the "rest" time as allowed, and bringing patients to the department, starting them on therapy and then allowing rests.

The only way to curtail this activity is to clearly establish policy, describing the true meaning of concurrent therapy. Then, on medical review, along with the medical record request, require a work / labor log along with their billing log for all patients during that period. This would identify, for the period under review, the therapists, assistants and aides that were available, the times that they were available; also how many claims were billed, not only to Part A, but Part B and other payers.

I truly believe that most therapists want to do what is correct, but, either because of lack of knowledge or because of direction from management and/or fear of loss of job continues with non-compliant practice.

Proposed Refinements to the Case-Mix Classification System

I believe that this would be a severe mistake to eliminate the grace days for the PPS assessments. There appears to exist amongst MDS coordinators and facility administrators a lack of understanding of the correct use of grace days and the remaining perception that use of them is a red flag. My recommendation is that, rather than eliminate the grace days, the grace days are integrated into the recommended assessment reference dates and the existing days for the reference assessment days be changed to more accurately reflect the needs of the patient for the payment period. For example, presently the 30 day MDS can have an ARD of day 21 to day 29. Use of day 21 as the ARD takes into account day 15 thru day 21; this assessment is supposed to reflect the care the patient needs day 31 thru day 60, so why is the patient assessment based on their need in the 3rd week of stay? It would be more realistic for this assessment to have an ARD window of 9 days starting for example on day 28 thru day 36. Again, when looking at the 60 day MDS presently the ARD can be anywhere from day 50 through day 65 (including grace days). Again, a more realistic time frame could be from day 57 through day 65.

With the present system, eliminating the grace days for the 30 day, 60 day and 90 days assessment would not have significant effect, however, eliminating them for the 5 day and 14 day would. For the 5 day, eliminating the grace days would produce the situation that they are supposed to eliminate, i.e. the rush to get the patient started on therapy the day they are admitted. For the vast majority of the patients admitted to SNF, being evaluated on the day of admission cannot produce an appropriate assessment of their needs, especially when it is done after 3:00 in the afternoon. Most patients admitted today are medically complex patients who, just as the Federal Register identifies, need to stabilize so that the evaluator (therapist) can more accurately assess their need for rehab services. Even today, there exists with some companies, the expectation that a significant number of patients will be rugged into the very and ultra high categories. With this policy, the pressure will be significant on the therapists to evaluate the patient no matter what time of admission.

Eliminating the grace days for the 14 day assessment leaves only a 3 day window. From my experience, it appears that day 11 is utilized for a good proportion of patients, again using a look-back period of 1st and 2nd week to pay for the 3rd and 4th weeks. Incorporating the grace days into the overall ARD would allow changes that again more accurately reflect need.

By incorporating grace days into the ARD range, it would be more likely that these days would then be utilized to produce an appropriate payment level.

Submitter : Dr. Russ Newman
Organization : American Psychological Association
Category : Other Health Care Professional

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1282-P-101-Attach-1.DOC



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

July 12, 2005

Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
Attn: CMS-1282-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: The proposed rule on the prospective payment system and consolidated billing for skilled nursing facilities for fiscal year 2006. File code: CMS-1282-P

Dear Dr. McClellan:

I am writing on behalf of the American Psychological Association (APA), the professional organization representing more than 150,000 members and associates engaged in the practice, research and teaching of psychology. We wish to take this opportunity to submit comments concerning the proposed rule on the prospective payment system (PPS) and consolidated billing for skilled nursing facilities (SNFs) for fiscal year 2006.

Our concern about consolidated billing for SNFs involves the Centers for Medicare and Medicaid Services (CMS) actions in designating several Current Procedural Terminology (CPT) codes as "always therapy" codes for purposes of PPS. Medicare's definition of "therapy" appears to be based on the language in section 4541 of the Balanced Budget Act of 1997 (P.L. 105-33) that identified outpatient rehabilitation therapy services as physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP) services. Any restrictions on billing for "therapy" services, however, are not restricted to physical therapists, occupational therapists, or speech-language pathologists. Once a CPT code is designated by CMS as representing a "therapy" service then direct billing for that service is restricted, if not prohibited, even when it is performed by a physician or other health care practitioner. It is unclear what criteria CMS now uses to determine what it considers to be a "therapy" service other than the CPT code it was billed under.

For example, in Change Request No. 3683, issued on January 21, 2005, services under the CPT testing codes 96110, 96111, and 96115 were bundled into the Part A facility services. It is our understanding that as a result, psychologists can no longer directly bill Medicare Part B for services under these codes. According to CMS staff psychologists must now contract with the SNFs to provide services under the codes to SNF residents.

This action interferes with psychologists' well-established authority to independently treat Medicare beneficiaries and receive reimbursement for their services. In 1989 Congress amended the Social Security Act to expand Medicare Part B coverage of psychologist

services to all settings. By preventing psychologists from billing Medicare for testing services in SNFs, CMS will be contradicting psychologists' rights under Federal law.

CMS should not consider testing and assessment services provided by psychologists to be "therapy" services as they are distinct from PT, OT, and SLP services. Each of these other professions brings a different perspective to healthcare. Physical therapists concentrate on gross motor movements with the goal of preventing injuries and helping individuals to recover. Occupational therapists specialize in fine motor movement and activities of daily living. Speech language pathology involves evaluating, diagnosing, and treating speech, language, and swallowing disorders.

Psychologists have on average seven years of graduate education in human behavior. In order to become Medicare providers, a psychologist must hold a doctoral degree in psychology and be licensed to furnish diagnostic, assessment, preventive, and therapeutic services. Psychologists utilize the CPT testing codes to determine a patient's cognitive abilities such as thinking, judgment, attention, and memory. Among the various healthcare professions, psychologists have the most expertise in assessment. For example, in 2003 Medicare reimbursed psychologists for providing over 96 thousand neurobehavioral status exam services to beneficiaries.

When psychologists provide services under codes that are also utilized by other healthcare professionals, the status of their services should not change. Psychologists using these codes for testing and assessment have provided beneficiaries with qualified psychologist services as defined under the Social Security Act and should always be able to directly bill Medicare for those services.

We are asking CMS to exempt services furnished by psychologists from the restrictions placed on "therapy" services that were intended for PT, OT, and SLP services. We would be happy to work with the agency to resolve this matter as efficiently as possible. If we can be of any further assistance please contact Diane M. Pedulla, J.D., Director of Regulatory Affairs, by telephone at 202-336-5889 or by e-mail at dpedulla@apa.org.

Sincerely,

Russ Newman, Ph.D., J.D.
Executive Director for Professional Practice

Submitter : Ms. Penny Piper
Organization : Lincoln Hospital LTC
Category : Nurse

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

I am opposed to removing the Lookback period from the MDS as it will have a negative impact on our final RUG rates.
I also am opposed to eliminating grace days. It is necessary to have the flexibility to use them especially when we are faced with scheduling around and through weekends with holidays either on Fridays or Mondays.

Submitter : Ms. Trisha Kurtz
Organization : JCAHO
Category : Private Industry

Date: 07/12/2005

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-1282-P-103-Attach-1.DOC



Joint Commission

Setting the Standard for Quality in Health Care

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: Comments on the proposed rule "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006." Specifically, the section that addresses "Proposed Refinements to the Case-Mix Classification System."

File Code: CMS-1282-P

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) appreciates the opportunity to comment on the proposed rule that would update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs), for fiscal year 2006. Founded in 1951, the Joint Commission is the nation's oldest and largest standard-setting and accrediting body in health care. The Joint Commission evaluates and accredits more than 15,000 health care organizations in the United States, including the preponderance of our nation's hospitals. The Joint Commission is also active internationally and has provided consultation and accreditation services in over 60 countries.

In 1966, the Joint Commission established the Long Term Care (LTC) Accreditation Program to support the delivery of safe, quality resident care. Today, the program has more than 1,500 accredited organizations, including long term care, skilled nursing, and assisted care facilities. A recent study comparing the performance of accredited and non-

accredited LTC facilities showed that accreditation is associated with better resident outcomes, lower risk and improved quality. Specifically, the study—conducted by LTCQ, Inc.—found that accredited facilities have

- fewer quality of care deficiencies,
- fewer complaint survey deficiencies,
- fewer substantiated complaint allegations, and
- a lower rate of facility-acquired pressure ulcers.

As a leader in promoting safe, quality care in health care organizations, the Joint Commission would like to take this opportunity to respond to the request for comments on the use of pay for performance (P4P) as a tool to improve the quality of care services provided in SNFs. The Joint Commission is supportive of efforts that strive to move away from the current payment system that rewards utilization to a system that aligns payment with the delivery of safe, efficient and high-quality health care. Like CMS, the Joint Commission recognizes that there are a number of issues that need to be addressed in order to implement a SNF P4P program that provides the appropriate incentives for improving the quality of health care services. Nevertheless, because it is widely recognized that financial incentives are among the most powerful tools for bringing about behavior change, CMS should work with pertinent stakeholders to resolve these issues.

The Joint Commission is also very concerned that CMS does not use a set of principles to guide the implementation of P4P programs. We invite CMS to consider the P4P Principles developed by the Joint Commission’s Board of Commissioners, as well as the P4P principles developed by other leading health care organizations, such as the American Medical Association and America’s Health Insurance Plans. Joint Commission’s P4P Principles are found at

http://www.jcaho.org/about+us/public+policy+initiatives/pay_for_performance.htm.

We believe that CMS will find commonality among these sets of P4P principles that will provide useful guidance for implementing P4P programs.

Finally, we would like to point out that the Joint Commission views P4P programs as an incremental step in the process of developing a system that rewards providers for quality and efficiency. As currently constructed, P4P programs only focus on a small segment of the care provided. Although this small segment can be used to demonstrate the benefits of realigning payment incentives, we do not believe it will result in the transformation changes that are needed to reform the payment system. In the long run, CMS and other health care stakeholders will need to work toward developing payment methodologies that encourage all providers to focus on quality and efficiency for all services that are provided.