1 - H

Central Dakota Village
SMP Health System

June 3, 2005

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

To Whom It May Concern:

I am submitting a statement regarding pending Medicare changes in regard to the Qualifying Three-Day Inpatient Hospital Stay for SNF coverage.

I have worked in Long Term Care for almost thirty years and am currently involved and have been for several years with admissions and Medicare coverage for residents in our facility. I have seen major changes over the years with resident's ability to access Medicare A services when entering a Long Term Care Facility.

Several years ago there was little utilization of Medicare services in Long Term Care Facilities as the acute hospitals kept patients for a much longer hospital stay so they had the qualifying stay but received enough care and were able to discharge directly home.

Today, patients enter the hospital often under observation status, are then admitted inpatient with a determination made that they are unable to return home without more services and arrangements are made for Long Term Care placement without the patient receiving the qualifying stay. In the other scenario the patient enters the hospital under observation and as the allowable observation time is ending, the hospital determines the patient will not be able to go home, needs some added services as therapy to become stronger and works to place them in a Long Term Care Facility saying they don't qualify for inpatient care and are then placed in the facility without a Qualifying Three-Day Stay.

I am totally in support of changing the Qualifying Three-Day Inpatient Hospital Stay as the hospitals are utilizing the Medicare A benefits for their facilities in their best interest and the residents are entering the Long Term Care Facilities and are not receiving benefits they should be entitled too. When this was initiated in 1965, the intent was for beneficiaries requiring short-term, fairly intensive stays. Many of the elderly are frail and need recouping and rehabilitation time to maintain their independence. They are not getting the support which I understand was the original intent. Our world has changed since 1965 and Medicare must change with it.

Thank you for your time and consideration of my statement.

Sincerely,

Marilyn Lobsinger, RN, Wellness/Rehab Coordinator

501 19th St. N.E. • Jamestown, ND 58401 • 701-252-5660 • Fax 701-251-2643

Form letter 2-

The Oaks of Clearwater

FY 2006 SNF PPS Proposed Legislation

Date:6-7-05

To whom it may concern at CMS,

We are a proponent of the FY 2006 SNF proposed legislation that would refine the RUG classification (rug 3) case mix classification system. We feel that these new classifications will help the overall care of the residents. There is a high variable rate for each medicare resident that pertains to ancillary charges as well as other non-therapy services provided to these residents that are not reflected in the current RUG levels. This is a problem because you have many residents categorized under the same RUG level as others, but these residents have other care issues that require more attention by the professional staff and other outside resources that are required to properly treat these residents. We also feel, as a not-for profit facility that any payment that will help offset the 50% of the add on payments that are being eliminated by the refinements. It is in our interest to provide the best possible care possible to our residents and we feel that the rule of FY 2006 SNF in the upcoming proposed regulation will only help benefit these residents even more.

Sincerely,

Illinois Hospital Association

JUN 24 2005

June 22, 2005

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

ATTN.: CMS-1282-P

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006; Proposed Rule, Federal Register, Volume 70, No. 96, Thursday, May 19, 2005

Dear Dr. McClellan:

On behalf of our approximately 190 member hospitals or health care systems, the Illinois Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule establishing new policies and payment rates for inpatient skilled nursing services for fiscal year 2006. The Hospital Association presents the following comments for your consideration:

PAYMENT PROVISIONS:

- **Expansion of Resource Utilization Groupings (RUGs):** Pursuant to the Balanced Budget Refinement Act of 1999, the Centers for Medicare and Medicaid Services has refined its categorization of medically complex patients. The agency has established nine additional Resource Utilization Groupings that include Medicare beneficiaries who qualify in both the Extensive Services category and the Rehabilitation Services category. The agency has concluded that this combined "Extensive plus Rehabilitation" group will improve the accuracy of payments based on clinical needs. **IHA supports CMS in its continuous refinement of the patient categories; however the Association has reservations about the age of the database being used (2001). Do these new categories accurately represent current patient treatment patterns? Is more current data available?**

- **Elimination of Temporary Rate Add-Ons:** Current regulations provide that payments to skilled nursing facilities for services provided to Medicare patients be adjusted for the following:

    1. A 20% add-on to the case-mix adjusted rate for twelve specific extensive, special care or clinically-complex categories and

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2. A 6.7% add-on to the case-mix adjusted federal rate for the fourteen rehabilitation RUGs.

The Balanced Budget Refinement Act of 1999 mandated that these adjustments were effective until CMS refined its original case-mix system. Because the agency is expanding the number of RUG categories from 44 to 53, it is proposing to eliminate these add-ons. **The Illinois Hospital Association has a major concern with this approach in that CMS is not implementing it, along with the case-mix refinements, in a budget-neutral manner.** Table 12 projects the estimated total impact of specific provisions in the proposed rule. While the RUG refinements are estimated to increase total skilled nursing payments by 3.0%, the elimination of the add-ons will reduce payments by an estimated 6.0%; this "deficit" effectively negates the market basket percentage increase of 3.0% provided for by current law, resulting in a 0% net change in Medicare payments from 2005 to 2006. **IHA recommends that CMS isolate the case-mix refinements and the add-on elimination, and implement those policies according to a separate, budget-neutral, approach. This approach would not only minimize the amount of payment redistributions among facilities, but would also allow facilities to receive the full inflation update that they are entitled to, irrespective of the mix of patients they treat.**

WAGE INDEX CHANGES:

- **Use of Core-Based Statistical Areas Data:** The proposed rule incorporates the use of Core-Based, Statistical Areas (CBSAs) to establish the area wage indices for Medicare payments in fiscal year 2006. The CBSAs were the result of analyses by the Office of Management and Budget (OMB) based on Census 2000 information and were first used in the calculation of Medicare payments in FY 2005 as part of the Medicare acute inpatient payment methodology. According to this skilled nursing proposed rule, the revised wage indices would be effective for services rendered between October 1, 2005 and September 30, 2006. The labor component accounts for approximately 76% of the Medicare payment rate for skilled services; this component is adjusted by the specific wage index. Consequently, any significant change in the index value from one year to the next can have serious financial repercussions on the organization. IHA has noted that the FY 2006 wage index is based solely on the values as set by the Census 2000, CBSA data.

  In the proposed rule, CMS explains that it is not looking into either a hold-harmless or transition policy in its application of the CBSA wage index values. Nor does the agency seem especially concerned about urban facilities that may be classified as rural under the new CBSA definitions. Its justification in both instances is that according to its research, only a very small number of facilities is affected. **The Illinois Hospital Association strongly objects to the FY 2006 wage index values that are based solely on the CBSA data, due to the severe financial impact that some of these nursing facilities will encounter.**

For example, in FY 2005, Lake County was part of the Chicago Metropolitan Statistical Area; consequently, its Medicare wage index value was 1.0852. If Lake County were still part of the Chicago MSA, its wage index value for FY 2006 would be 1.0838 according to Table A of the proposed rules. However, for FY 2006, Lake County is established as a separate CBSA, and its proposed wage index value is 1.0440, a 3.8% reduction from the previous year. For providing Medicare services to skilled nursing patients in FY 2006, facilities in that area will be reimbursed at lower rates than in FY 2005. IHA has concerns that any payment reductions in any areas could lead to severe financial hardships, closing of some skilled nursing providers and ultimately, lack of access to this vital service by Medicare beneficiaries. **Therefore, IHA recommends that, at the very least, CMS incorporate the same hold-harmless methodology for the skilled nursing wage index that it applied to acute inpatient services in 2005; i.e., if the FY 2006 CBSA value results in a higher wage index than the MSA value, the CBSA index is fully implemented. However, if the FY 2006 CBSA value is lower than its MSA counterpart, then the FY 2006 wage index is a transitioned value consisting of 50% of the MSA value and 50% of the CBSA value. This approach is not only consistent with the "hold harmless" transition used in FY 2005 for acute inpatient services, but also gives those facilities that are disproportionately affected a one year time period to adjust to the new methodology.**

COVERAGE ISSUES:

- **Qualifying 3-day Hospital Stay:** CMS has asked for comments regarding the appropriateness of the 3-day, prior acute care hospital admission for Medicare skilled nursing patients. Specifically, the agency has asked for comments regarding patient treatment time in emergency room or observation units. **The Illinois Hospital Association recommends that, in determining the total time spent in an acute hospital prior to admission to a skilled nursing facility, CMS include patient time spent in either the emergency room or the observation unit in determining compliance with that requirement.**

Dr. McClellan, thank you again for the opportunity to comment. The Illinois Hospital Association welcomes the opportunity to work with your agency in the continued development and refinement of the Medicare payment system.

Sincerely,

Thomas A. Jendro

Thomas A. Jendro
Senior Director-Finance
Illinois Hospital Association
(630) 276-5516
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4-H

CNA CARLYLE NURSING ASSOCIATES, LLC

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

June 20, 2005

Please consider the following comments related to CMS-1282-P
"Proposed refinements to the Case Mix Classification System"

Regarding your request for comments on the impact of revising the MDS manual to include only those special care treatments and programs (MDS Section P1a) furnished to the resident since admission or re-admission:

The initial purpose of the MDS tool and the RAI process was to provide a comprehensive nursing assessment to assure adequacy and appropriateness of the resident's care plan. This appears to have been forgotten in your metamorphosis of the assessment tool into a payment tool. The fourteen day look-back period for the items in P1a of the MDS assures that treatments and conditions the resident received prior to admission, which may have long-term side effects, are identified and followed up on as needed in the care plan. Primary examples of those services are radiation and chemotherapy treatments, which have long-range effects on bone marrow, digestive, and integumentary systems even if received prior to admission to the SNF. The care plan needs to address those high-risk areas and provide adequate intervention in the event of any suppression or irritation of these systems. In addition, the importance of identifying the dependence on a ventilator and/or oxygen before admission to the facility is crucial in establishing an appropriate respiratory care plan and monitoring for adequacy of oxygenation. These are simply examples of those items in P1a that have long-term effects, with need for ongoing monitoring for risks and side effects of treatment.

Modifying the look back period for these and other items in P1a increase the likelihood that these items would be overlooked and ignored as factors contributing to the resident's current condition and care plan, especially as obtaining this information from some referrals sources is difficult and time consuming. (Although this information should be freely provided by referring institutions, many are reticent to provide information and several attempts are necessary to obtain adequate information of what transpired during the hospital stay.)

While I concur that there would be cost savings to the Medicare program by making this change to the look-back period, I believe it would be to the detriment of the health and continuity of care of the beneficiaries by ignoring the importance of a thorough, comprehensive assessment, which the MDS was initially designed to provide.

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Regarding the requests for comments on eliminating the estimated therapy in Section T on the five-day and Medicare readmission/return assessments and the use of grace days:

While this could potentially provide a cost savings, it would do so at the detriment of the providers who have begun therapy services in good faith, and then have had beneficiaries decide either to transfer to another institution, go home, or be re-hospitalized prior to five days of therapy being delivered. In many instances the treatment plan is for 500 minutes or more of therapy per week, when this occurs. If the resident elects to depart after 2 days of therapy treatment (over 200 minutes), without the estimated days and minutes of therapy in section T, they would not even RUG out into a rehab RUGS category since they did not receive 5 days of service. The facility would have provided a high level of service in good faith, and then not be reimbursed for these services. Retaining the estimated days and minutes allows for a reasonable manner for facilities to be reimbursed for services delivered in good faith, for those stays that have been cut short due to untimely discharges.

In addition, CMS has previously indicated in some of their releases, it is not always clinically appropriate for therapy services to begin on the day of admission to the facility from the hospital. Should the option of grace days be altered, without the estimated information in section T, beneficiaries would have to be evaluated on the day of admission to have 5 days of therapy treatment actually delivered to RUG out in a rehab category above a medium. Due to the frequent number of late in the day admissions to the facility, this would be a disservice to the beneficiary who may already be fatigued upon arrival. Keeping the estimated therapy service would at least allow a high RUGS category for those beneficiaries who can tolerate and benefit from a higher level of therapy services, but who are not evaluated on the day of admission due to clinical inappropriateness and/or fatigue.

Maintaining the use of grace days on the 5-day/Medicare return/readmission assessments is also a benefit to those beneficiaries who, due to orthopedic surgery and or neurological events, can benefit from and tolerate very high and ultra high level of services, but again are not appropriate for evaluation on the day of admission due to fatigue or clinical status. If a revision of the use of grace days is necessary on this assessment, decreasing it from 3 days to 1 or 2 days would accommodate for this scenario, and still allow the facility to meet the beneficiaries clinical and therapy needs at an appropriate level and providing the 5 days necessary to RUG into a very high or ultra high RUGS category.

Thank you for this opportunity to comment on these items.

Sincerely,

Janet Knoll RN, C RAC-C
Director of Medicare Operations

5-11

form letter

Saint Joseph Hospital
2900 North Lake Shore Drive
Chicago, Illinois 60657
773.665.3000

Resurrection Health Care

June 29, 2005

Mark B. McClellan, M.D., Ph.D.
Centers For Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS – 1282 – P
Post Office Box 8016
Baltimore, MD 21244-8016

Re: Proposed Changes to Skilled Nursing Facility PPS

Dear Dr. McClellan:

On Saint Joseph Hospital's Skilled Nursing Unit, we congratulate you on your proposition that 9 new RUG categories be added. We believe these categories will better describe the care that is provided to these needy patients.

We also recommend that you go ahead with work toward inclusion of the 24-hour observation period into the three-day qualifying stay. This will allow movement of patient out of acute level of care earlier and will in turn shorten patients' whole acute-through-skilled length of stay. An overall shorter length of stay will reduce exposure to institutional hazards such as nosocomial infections.

The proposed rule also discusses possible elimination of the "look back window" for consideration toward the burden of skilled care. Elimination of this activity concerns us and we hope this will not be implemented! We believe that there are events that occur in the acute stay which significantly impact the amount of care in the skilled setting and then would not be captured in RUG categories. An example of this burden is the increased frequency of nursing evaluation of vital signs and lab tests for the patient who recently received a blood transfusion. Another illustration of this point is a speech pathology swallowing assessment performed on a patient in a skilled setting who was recently extubated in acute setting. In this case, the speech service is not considered towards a particular RUG category unless treatment is in turn necessary and provided.

Thank you for your consideration of these thoughts, and the opportunity for the public to review and provide input into policy prior to its implementation.

Sincerely,

Elena Kurih
Director, Specialty Care Services
(773) 665-6253

cc: American Hospital Association
Illinois Hospital Association

Rehab
MANAGEMENT INC

June 30, 2005

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

Re: SNF PPS refinements for 2006

Gentlemen

One of your comments refers to the elimination of grace days, specifically for the5 day MDS assessment. I was stunned to read this comment. The Grace days are on of the most practical features of the MDS system. Stuff happens!!! There are snow days, patient illnesses, Therapist illnesses and many other reasons to trigger the use of grace days. The use of grace days allows the patient to received the care he/she needs and does not require the provider to provide care for which it is not compensated. This is a WIN-WIN and should remain in the PPS program.

Very truly yours

George T. Botens
Chief Financial Officer

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7-4

aahsa
creating the future of aging services

30 PM 5:13

June 29, 2005

Via: Fax and Mail

The Honorable Mark McClellan
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. McClellan:

As you know, the proposed rule to refine the Resource Utilization Groups for skilled nursing facilities (Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for 2006, CMS-1282-P) contained several errors that had to be corrected. These corrections were released just yesterday and made significant changes in the proposed regulation. This negates much of the work AAHSA has done to provide sound comments about the changes proposed in the rule. We suspect other organizations may find themselves in the same position.

Therefore, so that CMS may obtain meaningful public comments as required under the Administrative Procedures Act, AAHSA requests that CMS recall the proposed rule and republish it with the corrected information. In the alternative, to ensure the opportunity for adequate and accurate public review and comment, CMS must extend the comment period for the current proposed rule a minimum of 45 days.

Immediately following the publication of the proposed rule on May 13, we notified our members and requested their feedback on the potential impact of the RUG revision on their facilities. We received over 800 responses from our members, who almost unanimously reported substantial negative impacts for their facilities. Once the mistakes in the rule were discovered, we had to suspend the collection of input from our members and can only restart this process today.

We now have only 13 days of the original comment period left to gain member input all over again and to compile the responses into meaningful information for CMS. We cannot expect to obtain the volume of member responses in the remainder of the comment period that we received in the first six weeks following the initial publication of the proposed rule, especially since the remainder of the comment period contains a three-day holiday weekend. The original notice in the Federal Register allowed for sixty days for the public to comment on the rule. Effectively truncating the comment period to thirteen days would shortchange CMS as well as nursing facilities and other stakeholders.

2519 Connecticut Avenue, NW Washington, DC 20008-1520 | aahsa.org | 202.783.2242

As we at AAHSA have consistently indicated, we want to work in partnership with you to develop a rational reimbursement system for nursing facilities participating in Medicare. I therefore hope that you will take the necessary steps to provide a realistic opportunity for public comment on the proposed RUG revision. We look forward to your response and our continued work together on this issue.

Sincerely,

Suzanne M. Weiss
Senior Vice President, Advocacy

AMERICAN ASSOCIATION FOR RESPIRATORY CARE
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http://www.aarc.org, E-mail: info@aarc.org

8-1

July 1, 2005

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

Dear Administrator McClellan:

The American Association for Respiratory Care (AARC), a professional association representing over 37,000 respiratory therapist members, welcomes the opportunity to comment on specific sections of the FY 2006 proposed regulations for the Skilled Nursing Facility Prospective Payment System Update.

Case Mix Adjustment and Other Clinical Issues

The implementation of prospective payment systems (PPS) as the structure for the reimbursement of Medicare health care providers, combined with other financial changes and medical advancements to the health care system, has created new paradigms in the provision of patient care. Patients diagnosed with respiratory and pulmonary diseases and illnesses who were once cared for nearly exclusively in the inpatient hospital setting are now being discharged into other care sites, still requiring extensive respiratory therapy services. By the mid 1980's, with the implementation of the inpatient hospital DRG PPS, there was a noticeable increase in the number of Medicare beneficiaries being transferred to Skilled Nursing Facilities (SNFs). While the site of care may have changed, the needs of the patients and the services they required had not.

Over the years, the AARC has voiced its concern to CMS that appropriate recognition and adequate resources be assigned to cover the respiratory therapy needs of the Medicare beneficiary regardless of the care site. Under the Medicare SNF PPS, respiratory therapy services are considered non-therapy ancillary services. Most often respiratory therapy services are provided to the patient who has been classified into the Extensive Care Services category. We concur with the March 2005 assessment by the Medicare Payment Assessment Commission's (MedPAC) that current RUG-III classification system did not capture the direct costs of non-ancillary services including respiratory therapy services.

Respiratory therapy patients in the SNF setting often require intensive services, those services that require the skills and knowledge of the respiratory therapist. It is important

that SNFs have adequate reimbursement to employ the respiratory therapist rather than assigning the patient care to others with less knowledge and lacking documented competency in respiratory therapy modalities.

The AARC supports the proposed refinement of the SNF payment system and the creation of nine new RUG-III groups, which combine the Rehabilitation Therapy RUG-III with the Extensive Services RUG-III. We believe this refinement will provide a more equitable distribution of SNF resources allowing the SNF to more readily accept the more critically ill patients. Moreover, this adjustment should provide the facility the financial resources to utilize the respiratory therapist, rather than substitute other less qualified personnel, when respiratory therapy services are required.

Concurrent Therapy

The AARC is aware of the practice of providing concurrent therapy (sometimes referred to as "stacking" or "dovetailing") within the context of respiratory therapy. The Association continues to receive extensive, anecdotal reports from respiratory therapists across the country that their employers (in a cross-section of health care facilities, not just skilled nursing facilities) require respiratory therapists, often against their professional judgment, to perform concurrent therapy.

In respiratory therapy, concurrent therapy most often occurs when one therapist administers treatments utilizing small volume nebulizers, metered dose inhalers, or intermittent positive pressure treatments to multiple patients simultaneously.

Patient safety is the primary reason for respiratory therapists not to deliver care via concurrent therapy without a thorough patient assessment. Indiscriminate use of concurrent therapy may lead to declines in quality and may jeopardize patient safety. Aerosolized medications administered during treatments have potential adverse reactions. Recognition of these reactions is not possible if the patient is left unattended and thus a safety hazard exists.

The Joint Commission on Accreditation of Health Care Organizations (JCAHO) cites concurrent therapy as a problem. According to JCAHO, if concurrent therapy is done, there must be a clear indication for it and a policy and procedure that govern its application. It must be differentiated from treatments given individually. Concurrent treatments, when provided in order to meet the convenience needs of the respiratory therapy staff, is considered inappropriate by JCAHO.[1]

Sources of Concern Regarding Concurrent Therapy

Medical Errors: The appropriate administration of respiratory therapy involves the assessment and monitoring of the patient. Assessment and monitoring include the determination for the need for therapy, administration of medications, the type of medication delivery device, patient education, patient tolerance, patient coordination, and outcomes documentation [2,3,4]. Concurrent therapy may encourage the elimination of one

or more of these essential elements and could result in medical errors. According to recent reports by the Institute of Medicine, there are serious problems associated with medical errors, particularly medication errors [5].

Billing Errors: Concurrent therapy can cause billing problems and result in possible fraud. According to federal regulations for Medicare Part A services (i.e., hospital inpatient services), "respiratory therapy services cannot be recognized when performed on a mass basis with no distinction made as to the individual patient's actual conditions and need for such services." [6] Although Medicare services are reimbursed according to a prospective payment system, these payments are based on professional standards and the therapist's time spent in providing patient care.

Alternatives to the Practice of Concurrent Treatments

The AARC believes there exists service delivery models and strategies which can close the gap between the demand for services and an institution's ability to meet that demand without jeopardizing patient safety, care quality and cost containment objectives. Alternatives to concurrent therapy include the following:

Protocols

The use of established protocols may help respiratory therapists deliver appropriate and efficient care under conditions of an increased workload. Protocols are based on scientific evidence and include guidelines and options at decision points. [7] The use of protocols can help assure that all treatments have established indicators but also are highly effective in reducing the volume of unnecessary care. Evidence based literature exists supporting the use of protocols to minimize unnecessary treatments [8] and provide self-administration options for patients who demonstrate their ability to do so as documented by the respiratory therapists [9]. Research has shown that there exists a high percentage of misallocated respiratory therapy treatments. Indeed the range of misallocation, according to the scientific literature, goes from a low of 25% to a high of 60% depending on the modality [10, 11]. It is important to note that numerous studies have concluded that protocols can reduce the volume of unneeded care, and therefore, contribute to an overall reduction in workload. For patients who require bronchodilator therapy, protocols can be effective in switching patients from small volume nebulizers, to the less time-consuming metered dose inhalers administered via hand held spacer devices. Other technology such as breath-activated nebulizers can be incorporated into protocols to increase efficiency without jeopardizing patient safety or quality of care.

Developing a Formal Procedure to Assess Patients' Needs

The AARC recognizes that not all health care provider organizations are in a position to take advantage of the benefits of patient-driven protocols. The Association recommends that a policy and procedure be developed which governs the application of the practice of concurrent therapy. This policy should include assessment of the appropriateness of the order for respiratory therapy utilizing AARC's Clinical Practice Guidelines (CPGs). Numerous studies have observed that CPGs are an invaluable tool in assessing whether

the therapy in question is an appropriate allocation of resources. Moreover, if the therapy is appropriate, frequency of its administration should be evaluated as well.

Assessment of the patient is an indispensable component to this process, with patient safety and quality of care foremost. The patient's cognitive status, understanding of therapeutic goals, coordination and tolerance of the therapy must be considered. Moreover, the patient's attitude and ability to cooperate with the therapy should be recognized as indispensable to the success of the treatment itself. For example, the incidence of cognitive impairment among older people ranges from 30-50% in acute care hospitals, and 50-80% in skilled nursing facilities [12]. Finally, the proximity of the therapist should be taken into consideration, to assure adequate monitoring for quality and safety purposes.

Self-Administration

While this third alternative may not necessarily be applicable in the skilled nursing facility, we offer it in these comments for CMS consideration of the larger situation of concurrent therapy being performed or required in other care sites.

There are many instances where patients can be transitioned to a self-treatment program and thus avoid a significant demand for the therapist's time. Health care facilities should be encouraged to investigate this alternative in order to decrease the workload for respiratory therapists without compromising care quality and patient safety. Policies and procedures must be developed which govern patient self-administration of respiratory therapy treatments. This process should include a thorough assessment of the patient similar to the one described above. Patients can then be categorized as those who require the services of a respiratory therapist or those, who after appropriate instruction from a respiratory therapist, can self-administer their therapy. Patients in the first group would be treated the traditional way, while those in the latter group should be assessed and observed on a daily basis in order to assure that the therapy ordered is still appropriate, the patient's clinical condition has not worsened and the patient can still demonstrate correct technique regarding self-administration of the treatment.

Conclusion

The foregoing alternatives are not intended to be all-inclusive. The recurrent themes contained in each are patient assessment, safety, quality of care, appropriateness of the order, monitoring all aspects of the patient's response to therapy, and organizing a formal policy and procedure to implement the alternative in question.

The AARC urges CMS to develop policy regulations regarding concurrent therapy. Unless Medicare formally requires facilities to follow such policies, facilities will continue to operate in the most expedient manner. Professional respiratory therapists should not be coerced into providing concurrent therapy when it is against their professional judgment.

If the AARC can provide any further clarification on these issues, please do not hesitate to contact Cheryl West at the Association.

Sincerely,

John D. Hiser, MEd, RRT, FAARC
President

References

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9-H

June 29, 2005

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

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

BKD, LLP is one of the 10 largest CPA firms in the United States. We specialize in the long term care industry, serving over 1,000 skilled nursing facilities throughout the nation. We employ a number of nurses and nursing home administrators who help SNFs provide services and obtain reimbursement according the Medicare (and Medicaid) program rules and regulations. Our experience working with SNFs (and many other health care providers) gives us a unique perspective on the practical impacts of the proposed changes.

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

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

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Look-Back Period

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

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

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

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

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

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

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

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

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

Decrease or Elimination of the Grace Period

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

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

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

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

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

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

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

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

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

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

Elimination of Projected Therapy Minutes

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

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

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

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

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

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

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

Qualifying Three-Day Inpatient Hospital Stay Requirement

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

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

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

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

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

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

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

Summary

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

We respectfully submit our comments and appreciate your consideration when deciding on the proposed changes. Should you have any questions or if we can be of further assistance, please feel free to contact Mr. Darryl Bueker, Partner, **BKD, LLP** at 417 865-8701.

BKD, LLP

BKD, LLP

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

10-H

UNITED TRANSITIONAL CARE CENTER Post Office Box 1680 ▪ Clarksburg, West Virginia 26302-1680 ▪ Telephone 304/624-2782

June 28, 2005

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

Dear Sir or Madam:

Enclosed you find my comments on the proposed regulation changes for the Prospective Payment and Consolidated Billing for Skilled Nursing Facilities for FY 2006.

Our comments reflect the unique issues of a hospital based skilled nursing home. Should you have questions regarding my comments do not hesitate to contact me at my office 304-624-2879.

Sincerely,

R Kay Cottrill

Roberta Kay Cottrill LSW NHA

Attachment
(4 pgs)

File Code CMS 1282-P
Implementation Issues

Issue Identifier: Assessment Timeframe for Concurrent Therapy

There are instances when a therapist can treat two or more patients simultaneously such as within a room setting. One patient may be doing exercises and another patient may be learning transfer techniques. A licensed therapist who feels they are being forced to do an unlawful act should report it to the facility compliance manager.

Additionally it would be helpful if CMS gave the facility some examples when they feel concurrent therapy would be appropriate and examples where they feel it is not.

Issue Identifier: Qualifying Three-day Inpatient Hospital Stay Requirement

Having worked in a hospital based SNF I don't believe this would have a measurable impact either way. The idea that patients may be admitted to the observation bed for a qualifying admission to the SNF is not a true picture since the patient must still meet the skilled criteria and the skilled service must be linked to the acute care diagnosis.

Issue Identifier: Consolidated Billing

There are several items and services that fall into this category of high expense and low probability of use. We do not believe that CMS has taken into consideration some issues that affect the HB SNF (hospital based Skilled Nursing Facility) Our facility is HB and our average length of stay is between 14 and 24 days. We participate only in Medicare and provide care to many patients with a high acuity with complicated medical problems. We often provide the care that freestanding nursing homes will

not due to the low reimbursement for these costly patients. Often we have patients who do not progress the way we had anticipated and they need further long-term care in an area nursing home. Our state is a rural state and patients travel distances for hospital care. Our SNF also provides care for the patient. Many of those patients require long term care after a period of time in our SNF. When we transfer them to another SNF our facility must pay the ambulance transportation. We often pay well over the daily reimbursment rate for transportation to another SNF. We do not know the reasoning behind this regulation. It is the same for us with patients that come from a larger hospital. The patients may live in our community and have surgery or care at a larger more metropolitan hospital. Patients are transferred to our SNF and their attending physician want to see them for a follow up. Once again we are required to pay this expensive ambulance bill and if the physician does an x ray or lab work that is added on to it. An ambulance trip to the closest nursing home in our area is over $400.00. When you are paid $300.00 for care you can see how this impacts us. Our facility budgeted $1,500 dollars for ambulance transports this year. We are at midyear and we already have been billed over $3,000.

We are hoping that CMS will take another look at this area for relief for our hospital-based units who provided a much higher level of patient care.

Additionally we feel that prosthetics and orthotics are an expensive item that does not fall under the routine for our patients. These are high price and unusual items that need to be segregated from consolidated billing.

<u>Issue Identifier: Wage Index Data</u>

The labor market especially for Registered Nurses has blended because of the shortage of this licensed profession. It seems that no matter where you live, urban or rural, everyone is affected by the labor market. Our state being a rural state also has to fight for staff that travels across to our border cities and

states. One must consider the number of small hospitals who have closed due to changes in the economic climate. Where once there was a hospital in every small town many of these are now only emergency rooms or clinic and the population now travel to larger hospitals for care. Additionally when the labor market is so tight small facilities sometimes pay a higher wage due to recruitment difficulties.

Issue: Assessment Time Frames

1.The question is should the process for projecting anticipated therapy services during the five day MDs assessment be eliminated. We believe this should no be eliminated as it serves as an excellent tool for our therapist. Without this what would the payment be based on? Would this require a change in the MDS?

2.The question is should the MDS grace period associated with all MDS assessment be decreased or eliminated. We believe these grace days are very valuable for the beneficiary if used correctly. We may have a patient who on occasion to go to the hospital for dialysis or tests all day and is too fatigued for physical therapy on that particular day. Additionally a patient with several co-morbidities is too sick to participate on that day. It is fair to the beneficiary to give them a grace day to see if they will be able to continue their therapy goals. This is especially true of our HB SNF patients.

Issue: Proposed Refinements to the Case-Mix Classification System:

AS a provider of HB skilled services we are encouraged by the possibility of this change. We are often called upon to take patients that other skilled facilities will not due to their high acuity, expensive medications, and other intense resources. An example of this would be a patient needing 4-6 weeks antibiotic. Many physicians use extremely expensive antibiotics that are

necessary for a specific infection. Other examples include multiple wound therapy, specialized beds, vac therapy and others. Most freestanding facilities refused admission for these patients do to the high cost that do not begin to cover their expenses.

11-H
form letter

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400 West 23rd
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June 16, 2005

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

TO WHOM IT MAY CONCERN:

Thank you for the opportunity to respond to proposed changes in the Medicare Prospective Payment System for the 2006 fiscal year. The following comments are relative to "Proposed Refinements to the Case-Mix Classification System".

The comments herein are specific to the proposed possible modifications to the Minimum Data Set. We have significant concerns about each of the modifications to the current system including the look-back period, the use of grace days and projecting therapy minutes. We can only suspect that the proposals are related to what CMS might consider to be the inappropriate application of the rules (on the part of some providers) in order to maximize reimbursement through the manipulation of the system. We would suggest that the existing system of review and denial is sufficient to identify patterns of abuse. It is inappropriate and unfair to both good providers and to the beneficiaries to change a working system of assessment and clinical programs when the wrongful actions of a few are the driving force behind the change.

Look-Back Period:

The look-back period as it is currently implemented allows the facility to "look back" into the hospital stay of any Medicare eligible beneficiary to gather certain information pertinent to level of care necessary once the patient has admitted to the sub-acute. The accumulation of this data is necessary in order to plan for the provision of the appropriate care as well as to determine the RUG and associated reimbursement.

The RUG that will be affected to the greatest extent will be Extensive Services. It should be a matter of record that the most common defining service during the hospital stay that creates the SE category at the sub-acute level is IV medications. Most Medicare eligible patients who are admitted to the hospital (either through the ER or with a planned admission) have an IV started. If the IV is fluids only, currently the patient will be eligible for an SE category up to the 7th day following IV D/C. If the IV includes medications, then the patient is eligible for the SE category up until the 14th day

following IV D/C. *By identifying the IV as the defining medical service and not taking into account the reason(s) for the IV, CMS has created the situation for which modification is now being proposed.* A reasonable compromise might be to reassess the length of the look-back rather than to do away with it. CMS might disallow the hospital IV to impact any MDS other than the 5-Day. Perhaps CMS will want to reconsider the weight given to IV fluids in circumstances other than the treatment of dehydration.

While we recognize that there can be misuse of the IV look-back in certain circumstances, we are opposed to disallowing looking at all hospital delivered IV treatments. Many patients admit to the SNF mere hours after the IV has been pulled at the hospital. If the IV was, for example, to deliver chemotherapy, antibiotic therapy, coumatin therapy, blood transfusions or epogen, the patient will require a significant level of skilled nursing care for monitoring and treatment of symptoms associated with the causative medical condition. As it currently stands, the sickest of our elderly patients are those in the first week after admission following a hospitalization for infections, chronic disease exacerbations (CHF, COPD, cancer) and surgeries. These patients also debilitate quickly under those circumstances and might reasonably be candidates for a rehabilitation program but are not able to participate in any meaningful therapy program within the first week to 10 days. If the hospital look-back for IV meds is not allowed, there is a very real possibility that the sickest patients will have no RUG pathway to care. Surely, the intention of any changes to the current PPS system is not to disallow needed care to the elderly Medicare beneficiary.

The Grace Period

When PPS was initially developed, the use of grace days for rehabilitation patients on the 5-Day assessment was legitimately expected for a number of reasons associated with both the availability of the therapist and the patient. The reality of the 5-Day Assessment without the use of grace days is that patients must be evaluated by a licensed professional therapist on Day 1. In order to achieve any RUG at a level higher than Rehab Medium, the patient will have to be treated on all of the first 5 days. That includes weekends, holidays and inclement weather days.

Discharges from the hospital are not under the control of the SNF. It is the experience of many facilities that hospitals are prone to discharge patients on Fridays (typically in the afternoon). Regardless of the day of discharge, patients arrive at the SNF after 1:00 pm as a matter of routine. The current availability of therapists in most markets will not allow for 7 day per week schedules or week-end coverage. Many SNFs do not have Medicare units of sufficient size to support a full time therapist so must "share" a therapist with other providers. The coordination of available therapists with an unknown hospital discharge time-table will predictably result in poor coverage and personnel crises.

Patients are discharged from the acute level in fewer days resulting in sicker, less hearty patients at the time of the SNF admit. There is no value in a therapy evaluation taking place in the late afternoon or evening of the first day for a frail, elderly patient who has experienced upheaval, ambulance travel and who is both emotionally and physically

exhausted. While this is not a fair Day 1 description of all admitting patients, neither is it fair for a medical system policy to mandate that such a patient be required to endure such a program. A good clinical model is one that allows patients a day or so to adjust to their new reality and surroundings without compromising their recovery. The use of grace days on the 5-Day MDS accomplishes this end. The use of grace days on any assessment should be for the provision of the appropriate clinical program for the patient that results in a fair reimbursement to the provider.

If abuse of the system has occurred, the appropriate CMS response should be to identify the individual abusers and take appropriate action. Changing a system that is well designed punishes the beneficiary and honest providers.

Projected Therapy

There are legitimate reasons to project a therapy RUG on the 5-Day MDS. The ability to do so financially protects a provider who, in good faith, has assessed the needs of a patient and developed a plan of rehabilitation that is interfered with in unforeseen ways. Those typically include *unplanned* discharges prior to the 5-Day ARD and inclement weather or holidays precluding a traveling therapist from providing the service.

We acknowledge that there is an opportunity for unscrupulous providers to use projected minutes to achieve an unrealistic RUG for 14 days of reimbursement for which the level of service is not provided. That would not typically occur by happenstance. If concern about *upcoding* is the reason for disallowing projected therapy, it would be far better to identify those providers who are abusing the PPS system and take appropriate action toward them. The UB92 provides the intermediary with irrefutable evidence of any pattern of inappropriate use of projected rehabilitation minutes.

Currently, if any unforeseen or uncontrollable issue arises in the first 5 days of SNF rehab stay, the only options to maintain a reimbursement model are the use of grace days or projected minutes. If both of these options are removed, there will be significant concern about the method within which a SNF can recoup loses.

Combining Extensive Services and Rehabilitation to create 9 new RUG categories

The combined nursing/rehab model might be of significant value in those situations when patients "qualify" under both Extensive Services and Rehabilitation. One must assume that the SE qualifiers are proposed to be facility based only. On those occasions that a rehab patient has an IV started in the facility, there will be sufficient reimbursement, under the proposal, to pay for both the IV and the contract therapy service. While this is not currently a common scenario, it does occur from time to time. At the point that an IV would be ordered after an admission to a SNF, there are, typically, fairly significant health and stamina issues involved that frequently preclude the continuation of a therapy program at that point. At that time, the appropriate response is to proceed with an OMRA and focus the appropriate care for the patient.

Including observation days in the 3-day hospital stay requirement for Part A services.

We agree with CMS that the level of care in a hospital observation bed is frequently undistinguishable from the care provided after an admission to the acute bed. Since PPS was implemented, most SNFs have had the experience of inadvertently counting the observation midnight, in error, and creating a no-pay situation for the significant level of care that they had then provided. Counting observation midnights will help to insure fair compensation for subsequent sub-acute care and will not compromise the services to the beneficiary. We are grateful for this acknowledgement and proposed change.

It has been our intention to offer well-supported opinions and suggestions based on the experience of providing services to Medicare beneficiaries since the implementation of the Prospective Payment System. It is to no ones advantage when the system that mandates the parameters of health care and reimbursement is so modified as to disallow ethical providers the opportunity to be fairly compensated for reasonable and necessary services provided. We respectfully request that you consider our efforts toward this end and are hopeful that you will do so.

Sincerely,

Nora Faulkner, Adm.

Nora Faulkner
Administrator

12-H

MEDPAC Medicare Payment Advisory Commission

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Glenn M. Hackbarth, J.D., Chairman
Robert D. Reischauer, Ph.D., Vice Chairman
Mark E. Miller, Ph.D., Executive Director

July 8, 2005

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

Re: File code CMS-1282-P

Dear Dr. McClellan:

The Medicare Payment Advisory Commission (MedPAC) is pleased to comment on CMS's proposed rule entitled *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006*, Federal Register/ Vol. 70, No. 96 (May 19, 2005), which updates the payment rates for the skilled nursing facility (SNF) prospective payment system (PPS) and proposes refinements to the SNF case-mix classification system. After a general overview, detailed comments on specific elements of the proposed refinement appear under the captions that correspond to the relevant section in the proposed rule, where applicable.

Refinement overview

The SNF prospective payment system's distribution of payments results in inadequate payment for nontherapy ancillary (NTA) services, such as prescription drugs and IV therapy. This issue has been a matter of concern for the Congress, MedPAC, GAO, CMS, industry stakeholders, and researchers since the early years of the SNF prospective payment system. Inadequate payment distribution for NTA services is a function of the design of the payment system—while the NTA costs were part of the total costs used to develop Medicare's SNF base payment rates, NTA costs were not used to develop the weights that adjust the base payment rates according to patients' resource use. As a result, the payment system does not distribute payments for NTAs according to variation in expected NTA costs across different patient types.

MedPAC is also concerned about the incentives regarding the provision of therapy under the current payment system. The current system has two incentives related to the provision of therapy. The first is for SNFs to provide additional therapy to achieve higher payment even though the patient may not benefit from additional therapy. The second is to provide the fewest number of minutes of therapy in the highest achievable payment group.

We conclude that the proposed refinement is inadequate because it does not directly target payment for nontherapy ancillary services and makes no change to the policy of basing a substantial portion of the SNF per diem payment on the amount of therapy provided. Other reform options that demonstrated improved explanation of NTA and total cost variance are available to CMS. We request that research conducted by the Urban Institute and others on the performance of various RUG refinement options as well as alternative case-mix systems, such as APR-DRGs, be made available as soon as possible to enable a broader policy discussion on the merits of the current and alternative case-mix systems.

Case-Mix Adjustment and Other Clinical Issues

NTA payment

CMS proposes to retain the RUG-based structure of the payment system and add nine new extensive services plus rehabilitation payment groups. These new groups would become the highest payment categories. CMS also proposes to increase the value of the nursing weights of the new and existing payment groups "by calculating a percentage increase that would increase aggregate payments." CMS describes these refinements as a "means of achieving more appropriate payment for these services without the potential drawbacks of our earlier proposal in terms of complexity and addressing variability in utilization." We are concerned that this refinement does not help achieve this goal of more appropriate payment because the payment system does not have a mechanism for targeting payment for nontherapy ancillary services.

The proposed refinement would increase payments for one group of patients that has among the highest NTA costs on average—patients who qualify for extensive services plus rehabilitation. CMS uses the higher NTA costs of extensive services plus rehabilitation patients, relative to patients in rehabilitation alone groups, to justify, in part, creating separate groups for these patients. But at the same time, the patient group with the highest average NTA costs would have its payment rate reduced under the proposed refinement and loss of the add-ons. Payment for extensive services patients, who had higher average NTA costs than those who classify into all other categories, is actually lower, relative to both the previous year and relative to other payment groups. The following example shows that while the payment for one of the new extensive services plus rehabilitation groups increases 3.5 percent under the new payment system, the per diem payment for a patient in an extensive services group is reduced by 11.8 percent.

Per diem payment changes for three RUGs using revised proposed urban rates

	RUG-44 (FY 05) + add on	RUG-53 (Jan. 06)	Difference RUG-44 and RUG-53
High rehabilitation (RHC)	$352.49	$342.09	-3.0%
High rehabilitation +extensive services (RHC/RHX)	$352.49	$364.74	3.5%
Extensive services (SE3)	$369.41	$325.67	-11.8%

Source: "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities—Update—Notice," Federal Register, Vol. 69, No. 146 , July 30, 2004 and "Preliminary analysis of RUG-53 case-mix adjusted federal rates and associated indexes—urban, updated for 2001 data," http://www.cms.hhs.gov/providers/snfpps/PrelimAna-cma-urban.pdf.

CMS is increasing the nursing weights of all payment groups because of variability in NTA costs within and across groups; but uniformly increasing payments to all groups is not a proxy for better targeting NTA payments. CMS asserts that an alternative approach—using a separate index (as proposed in the 2000 rule and further developed in Urban's research) based on conditions that predict NTA costs to determine payment for NTA services—would create excessive complexity by increasing the number of payment groups. We find this argument unpersuasive. Such an index does not have to create additional groups; it can be considered a modifier to an existing system. In addition, complexity should be weighed against improving the targeting of payment in the skilled nursing facility PPS. If CMS releases it, the Urban Institute's research could facilitate a more complete discussion of the merits and feasibility of various index approaches for NTA payment. Finally, we can find no analytic basis for CMS's decision to determine the size of the increase in the nursing weights using the size of the inpatient rehabilitation outlier pool.

Therapy payment

With respect to our second major concern with the SNF PPS—payment based on the amount of therapy provided or estimated to be provided—we find that the proposed refinement does not correct incentives to provide therapy to maximize payment. We recognize that this problem likely requires fundamental changes to the payment system and that prospectively determining the appropriate amount of therapy is difficult.

That said, we have concerns about the therapy weights used to adjust payments under the proposed refinements. More than a month after publishing the proposed rule, CMS acknowledged errors in the therapy weights; they then published recalculated weights

that also use newer data on their website. To recalculate these weights, CMS made adjustments, including an adjustment to the therapy and nursing weights to make aggregate payments equal under the proposed new and old payment systems. We also have questions about the accuracy of the recalculated weights because the method for recalculating the therapy weights appears inconsistent with the previously used method. We are concerned that these issues have created confusion in the policy community and among industry stakeholders. CMS should provide correct weights and a complete, transparent explanation of all their methods for deriving the weights in time for public review and comment.

As a final note on the therapy weights, we would like to point out the heterogeneity in therapy provided to the highest newly created payment groups, RUX and RUL. Because of CMS's method for developing the therapy weights, these two groups have the same therapy weight applied to derive their therapy payments, despite having a more than four-fold difference in the average minutes of therapy provided per day.

Proposed Refinement to the Case-mix Classification System

CMS asked for comments on issues related to the Minimum Data Set (MDS) instructions. Our comments on these specific issues follow.

Elimination of the look back instruction in the MDS

Currently, SNFs are instructed to look back a specified number of days when answering questions on the MDS about patients' conditions and services or treatments that a patient receives. As a result of this look-back, the information on the MDS may refer to conditions that were present and treatments received during the prior hospital stay. This proposed change would restrict the data collected on the MDS to services furnished during the SNF stay. Although the rule does not mention this, research by the Urban Institute found that conditions and treatments that occurred only during the SNF stay better predicted per diem SNF costs than those same conditions combined with treatment provided during the preceding hospital stay. For this reason, we believe that eliminating the look-back period for payment purposes is appropriate.

Accurate patient classification is especially important in light of the addition of the nine new extensive services plus rehabilitation RUGs because the look-back period is currently used to determine whether a patient qualifies for the extensive service category. Eliminating the look-back period has implications for estimating the number of SNF patients that qualify for the proposed new payment groups. CMS should clarify whether their estimation of the number of days on the new payment groups is based on classification with or without the look back.

Elimination of the projection of anticipated therapy on the 5-day PPS assessment

Currently, on the first MDS assessment a patient can be categorized into a high, medium, or low rehabilitation group using an estimate of the amount of therapy that will be provided, rather than the actual amount provided, during the first two weeks. For all subsequent assessments, the beneficiary must have already received the minimum amount of therapy that defines a group in order to be categorized in that group. GAO found that half of the patients initially categorized into high or medium groups did not actually receive the minimum minutes to be classified in these groups. Eliminating the use of estimated therapy minutes to classify patients would likely reduce the mismatch between estimated and actually provided therapy.

SNF quality measurement

The Commission has recommended that the Secretary require assessment of SNF patients' functional status at admission and discharge. In addition, recently introduced legislation also calls for the collection of these data. The Secretary has the authority to act on MedPAC's recommendation, which could be implemented with little provider burden and is critical to facilitating assessment of patients in the SNF setting. Without an assessment at discharge it is currently impossible to know to what extent SNF patients improved during their stay. CMS should take this vital step towards quality measurement in the final rule.

Coordinated payment and delivery of post-acute services

CMS expressed the need to investigate a more coordinated approach to payment and delivery of post-acute services that focuses on the overall post-acute episode. We are pleased that CMS is thinking about this topic. As we testified before the U. S. House Ways & Means Subcommittee on Health in June, this is an agenda item for MedPAC as well and we look forward to working with CMS on this complex and important issue.

Proposed revisions to the SNF PPS Labor Market Areas

CMS is proposing to define urban areas as metropolitan statistical areas or metropolitan divisions; micropolitan and outside CBSA counties would be considered rural. This proposal is consistent with the labor market areas that were adopted under the IPPS on October 1, 2004. However, unlike inpatient hospitals, SNFs going to a lower wage index under the new geographic definitions will not be afforded a transition period in which their wage index would be a blend of old and new.

CMS is proposing to adopt the new labor market designations effective January 1, 2006. As we commented on the IPPS proposed rule, facilities should be treated equitably, and large payment changes should be phased-in over time in a budget-neutral manner. The payment effects of the new labor market designations should be phased-in in the same manner as they were for inpatient hospitals.

MedPAC appreciates your consideration of our comments. If you have any questions or need clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director at (202) 220-3700.

Sincerely,

Glenn M. Hackbarth
Chairman

GMH/kl/w

13-14

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Comment on CMS-1282-P: Proposed Rule for 2006 SNF PPS System

July 5, 2005

Greetings,

Following are the comments we have prepared in response to the Proposed Rule for FY 2006 SNF PPS System. The comments are a blend of viewpoints from some of our frontline staff and our corporate officers.

If you would like or require any further clarification of our comments, please contact us. As the primary author, you may reach me at the Carespring address information listed above, or email me at johnm@carespring.com .

Thank you for your consideration,

John Muller, PT
Vice President for Rehabilitation Services
Corporate Office
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Comment on CMS-1282-P: Proposed Rule for 2006 SNF PPS System

B-2-a: Constructing the New RUG-III Groups:

We do feel this is an appropriate approach to the RUG-III system. Currently when a beneficiary is brought into the SNF as a skilled resident, in certain cases, we must choose to work toward a Nursing RUG such as a SE versus providing rehab that would put the beneficiary into a Rehab RUG. It is appropriate to have a group of categories that takes into account the nursing skill that is needed to follow beneficiaries being discharged from the hospital sooner and perhaps in a more acute state. These same beneficiaries also require therapy to maximize their overall functional independence, building functional strength and endurance. The proposed RUG levels should help beneficiaries recover from the spell of illness expeditiously and thoroughly so re-hospitalization is not required.

We have questions and are curious about the reasoning on the following proposals:

- Table 4a – Why & how do you arrive with the highest nursing component for the RM category then hierarchically work your way down in nursing component value as we work our way up in Rehab RUG categories?
- For example, the new RMX category will pay significantly more than both RHX and RVX. We feel this could adversely affect provider incentives to decrease therapy to beneficiaries requiring Extensive Services. You have encountered this "anomaly" before when the 20% add-on applied to RHC, RMC, and RMB and created rates that "were higher than the rates for some other, more intensive rehabilitation RUGs." You corrected this, we think rightly so, in a very timely fashion.
- We feel you may need to re-examine the Nursing index in all cases in the new 9 Rehabilitation plus Extensive Services categories. In our clinical experience many beneficiaries who currently would qualify for Extensive Services but require Rehabilitation do not fall into the Rehab Medium category but the Rehab High and Very High categories. The proposed RUG-53 does not reflect the intensity of nursing requirements in this category. A common and frequently occurring example, a beneficiary who has suffered a recent CVA and requires all three therapy disciplines, PT, OT, and ST. This beneficiary would certainly qualify into a RH or RV category remains very extensive care for nursing.

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Comment on CMS-1282-P: Proposed Rule for 2006 SNF PPS System

B-2-c: FR page 29079-80 Special Services Look Back – P1a

You comment 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 that were furnished exclusively during the period before SNF admission." It is critical to your new proposal of the nine (9) new RUG groups combining Extensive Services and Rehabilitation that we remain able to "look-back" into the hospital stay to see who does require Extensive Services. Keep in mind we are certainly not paid to provide these services, the hospital is. Indeed beneficiaries who trigger these areas of the MDS do require more services, monitoring, and skilled treatment to bring back to baseline. Eliminating the ability to look-back and get the most accurate assessment possible is incongruent with your proposal of the new categories.

You seek comment on the "potential savings" by eliminating the look-back provision. Once again PPS, as we understand it is a mechanism to be paid accurately and fairly based on the level of services we provide. The look-back period is only used for the first MDS, and then only appropriately to correctly identify beneficiaries who will likely require a higher level of care. The look-back drives accurate assessment, care planning, and, in fact, treatment delivery. The "potential savings" certainly can not outweigh the potential harm by eliminating our ability to use this data to drive the beneficiaries care.

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Comment on CMS-1282-P: Proposed Rule for 2006 SNF PPS System

B-2-c: FR page 29080 Comment on 5-day MDS Grace Days

Indeed the grace days on the 5-day MDS have been a source of misunderstanding since the inception of the system. We have a suggestion to stop calling the 5-day MDS the "5-day." We propose to continue using any day from day one (1) to day eight (8) as the Assessment Reference Date for the first MDS. The ability to flex the assessment reference date on this first MDS is critical to capturing the most complete picture of the beneficiary. In your model of PPS you instruct us to capture the most accurate picture of the beneficiary so that we may be reimbursed fairly for the amount of care they require. This accurate assessment helps us deliver appropriate care. Eliminating the grace days would create unnecessary rigidity in this critical assessment. This is the first time we are getting to assess the beneficiary and require the flexibility to capture items critical to developing the care plans. Beneficiaries that have had I.V. medications, suctioning, tracheostomy care, and/or use of a ventilator/respirator within the last seven (7) days of the assessment even if that was in the hospital are in a more tenuous state of health and require extensive services. Flexibility in setting the assessment reference date is critical to these beneficiaries receiving the appropriate care.

Use of the grace days also allows beneficiaries who will benefit from a higher level of rehabilitation to receive it and allows us to properly code for this level. Please keep in mind roughly 85% of beneficiaries are admitted to a SNF for therapy. We feel virtually no beneficiary wants or needs therapy services on day one of their SNF stay. For most beneficiaries we see, roughly 95%, day one (1) of the SNF stay begins late in the day after an eventful discharge process at the hospital, the transportation, and then arrival at a new facility. This is day one, in the early days of PPS therapist were required to come in and begin therapy as late as 10:00pm on Medicare beneficiaries because facilities were afraid to use the grace days; let us not return to this. Therapy services at a skilled level are defined by you as a five (5) day per week service. We work these five (5) days out of seven (7). With no therapy on day one (1) and then five (5) days of therapy through the next seven (7) calendar days, facilities need to use day eight (8) to get the most complete and accurate assessment of the beneficiary. Without the use of grace days we would not be able to capture the higher rehab RUG levels for those residents who require it.

As you implement the "Rule of 75" for IRF facilities, we at a SNF level will be accepting more and more beneficiaries who require a high level of therapy. Please take this into consideration when looking at the flexibility you have designed into the 5-day assessment. We think this system works extremely well as it is to allow the beneficiary

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the most thorough assessment and the most appropriate level of care. The issue is really in semantics of calling it a 5-day assessment. All other assessments have at least a seven (7) day look back period. Why would this most critical assessment be limited to day five (5) and potentially create difficulties for the beneficiary? Keep the flexibility and possibly look at renaming the assessment. You created a flexible system with grace days and we have often thought of your insightfulness and keeping the beneficiary at the front of your thought process.

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Comment on CMS-1282-P: Proposed Rule for 2006 SNF PPS System

B-2-c: FR page 29080 Comment on Elimination of the Projection of Therapy on 5-day MDS

This issue really ties into the use of grace days. When listening to lectures about the DAVe project it seemed one of the focus areas they had was to ensure facilities actually delivered the care they projected. We were surprised and shocked to think some facilities may be using this section of the MDS to project a beneficiary into a category then not deliver the care as a business practice. If this is the case it must surely be eliminated. We feel the projection is often used so that facilities do not use grace days. Again, early in PPS facilities were 'afraid' to use grace days. If we eliminate the term 5 day MDS and use any day from day 1 to day 8 as the Assessment Reference Date for the first MDS projections will be unnecessary and therefore could be eliminated.

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Comment on CMS-1282-P: Proposed Rule for 2006 SNF PPS System

B-7: FR page 29082-29083 Comment on Concurrent Therapy:

We encourage you to continue to acknowledge "that concurrent therapy can have a legitimate place in the spectrum of care options available to therapists treating Medicare beneficiaries, as long as its use is driven by valid clinical considerations." Medicare beneficiaries in a SNF setting are unique. They are not like outpatient Part B beneficiaries who likely have a single, isolated need for therapy say an injured rotator cuff, late affects of a TKR, or low back pain. They are not like beneficiaries in an IRF that require a minimum of 3 hours of therapy per day. Our beneficiaries in the SNF setting can require anywhere from 30 minutes per day from one therapy discipline to at least 2.4 hours per day over five (5) days in the Ultra High category. They are working on fundamental functional issues of transferring, ambulation or use of a wheelchair for mobility. They are learning exercise programs to strengthen muscles and systems debilitated by illness. They are relearning to dress, perform daily hygiene tasks, and household duties they will have to accomplish on a daily basis. They are re-learning to speak, swallow, problem solve, and balance a check book. They also may be re-learning life roles that have been drastically changed by a recent CVA or traumatic fracture. When they attain the fundamentals of function we move onto teaching and assessing higher level aspects of skilled care. Shumway-Cook (2003) has described eight dimensions of the environment that affect function. We teach and assess how beneficiaries function in each of these specific dimensions. You can ascertain that much of what we do is teach. What the beneficiaries do is learn.

Most of this learning is progressing through the stages of motor learning and being guided through skilled training strategies. This is where the ability to practice concurrently helps the beneficiary get better, in an expedited fashion, and attain a higher level of function. Motor learning has three (3) basic stages cognitive, associative, and automatic. At the beginning of any new task, treatment is delivered in a 1:1 model so the therapist can be sure the beneficiary cognitively understands the task and goals of the task. As the beneficiary demonstrates understanding they need to practice the task and associate it into their abilities. This can be effectively accomplished in a concurrent model. The therapist, using their skills, is able to observe, guide, correct, and facilitate as the task is being performed. The most appropriate stage for concurrent treatment is the automatic stage of motor learning. This is where we would use 'blocked practice' which is repetitive skilled practice to promote retention of the developed skill.

This is also the most opportune time to observe and perform safety assessments. Using skilled observation to see how a beneficiary will perform tasks that carry a high

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level of risk, i.e. cooking, transferring, gait, medical safety, insight into own deficits, etc. A beneficiary in a SNF will have to make many motor tasks automatic to return to at least the prior level of function, but we want more than that. Where possible we want to rehabilitate a beneficiary to a level they will not need to use the Medicare system again for a prolonged period of time.

There is also a psychosocial element of concurrent therapy. Beneficiaries who are treated concurrently often develop interpersonal relationships with each other that are motivational. Beneficiaries actually help each other through the stages of learning and, incidentally, recovery. It is helpful in the associative stages of learning to observe tasks that other beneficiaries are participating in and often they provide feedback to one another. Even when beneficiaries are at different stages in their rehabilitation, they can be quite inspiring to others. We often see beneficiaries who have been in therapy and are familiar with the SNF helping new beneficiaries acclimate and understand the setting. This anecdotally helps us achieve positive outcomes. These psychosocial elements would not take place in a 1:1 treatment model.

We believe the upcoming baby boomer generation will create an increasing ratio of boomers per skilled licensed therapist. We believe the use of concurrent therapy when appropriate allows the beneficiary to receive the amount of therapy required to get them to a high level of function, and ultimately save the Medicare system money. A strict adherence to 1:1 therapy delivery would minimize the amount of therapy delivered to Medicare beneficiaries likely lengthening their skilled stays and preventing their ability to reach their maximum level of function.

The changes that PPS brought to delivery of therapy in SNF were good ones. I am a therapist and have no tolerance for abuse of the system that allows me to earn my living. If there are management companies that are abusing this system perhaps a focus during annual survey visits may be an incentive to cease this practice. Currently the way we interpret the rules seems clear. We may work with no more than four (4) beneficiaries at one time that are working on their individual treatment plans. We think this is an appropriate number and do not exceed this. This does not in any way mean we are treating four (4) beneficiaries constantly throughout the day. We use our best judgement, stay extremely current on geriatric treatment strategies and use valid clinical considerations to guide how we deliver our treatment. In PPS therapy delivery is about the beneficiary not the therapist. I would suspect many of your comments about the 'evils' of concurrent therapy come from therapists that miss the pre-PPS model.

We have strong feelings on this subject grounded in research and clinical observations. If you seek testimony on this issue we would be glad to participate.

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Shumway-Cook, A., Patla, A., Stewart, A., et al. (2003) Environmental Components of Mobility Disability in Community-Living Older Persons. *Journal of the American Geriatrics Society, 51,* 393-398.

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1282-P
PO Box 8106
Baltimore, MD 21244-8106

07/07/05

Dear Sir or Madam:

Please accept this letter as my comment to the items discussed in The Federal Register dated May 19, 2005, file code CMS-1282-P.

Proposed Refinements to the Case-Mix Classification System

The proposal to increase the number of RUG's from 44 to 53 is an excellent one. I am greatly encouraged to see CMS addressing the costs of non-ancillary supplies in this manner. I am also pleased to see that CMS is recognizing that two patients that fall into the same RUG classification may have vastly different cost of care. You are showing your commitment to assuring beneficiaries access of care with the changes in the RUG refinement system. I look forward to your future research, and future proposals to continue to address this dynamic area. Thank you for your attention to this area, which allows facilities to provide the best care to beneficiaries.

There are three items in your proposal that I have concerns about. As you have invited comment on these areas, following are those concerns and my rationale for concern.

1. *Please reference page 29079-29080.* The elimination of a 14-day look back or a modification of the period to seven days would not reflect the care given in a SNF. A beneficiary may receive a medical procedure or treatment while in the hospital that requires skilled nursing observation and assessment for adverse side effects. When a patient receives a treatment (for example IV medications, suctioning, tracheostomy care, and ventilator/respirator use) they require continued skilled level nursing assessment while at the SNF. The 14-day look back acknowledges that the skilled assessment of a licensed nurse is needed as follow up to these treatments, for the full 14 day period. Skilled nursing assessment is necessary post decannulation of tracheotomy patients due to potential of laryngeal stenosis, tracheal granuloma and tracheomalacia. Discontinuation of mechanical ventilation leads to an increase in cardiac preload and afterload, which can cause left ventricular failure. Adverse effects of intravenous medications and fluid administration include thrombophlebitis, infection, fluid overload and medication side effects. Skilled nursing is warranted to monitor for these potential life-threatening side-effects of the above mentioned treatments. These events can, and do, present up to 14 days after administration. Therefore, keeping the 14-day look back

reflects the assessment and monitoring given in the Skilled Nursing Facility as a result of the treatments that were received in the hospital.

2. *Please reference page 29080.* You have invited comments on decreasing or eliminating the grace day period for the MDS assessment periods. The intent of the grace days is to reflect the care actually given to the patient, by allowing some flexibility in date selection. Flexibility is necessary to account for acute episodes that the beneficiary may have while in assessment time, but that do not generally reflect the care given on the whole of the assessment period. This flexibility is especially crucial on the 5-day assessment. Beneficiaries are often very tired on the day of their admission, and often are experiencing post-op pain. Levels of fatigue and pain affect the beneficiaries' ability to participate in therapy. By using grace days, facilities are more able to accurately show the level of therapy services that a beneficiary uses, while allowing them time to rest and adjust to placement in a new facility. I would suggest that educating nursing facilities how to use these grace days to the best benefit of the beneficiary would be more relevant in capturing the actual care given to the beneficiary than eliminating them.

3. *Please reference page 29080.* You have invited comments on the possibility of eliminating the projection of anticipated therapy services in Section T. As I stated earlier, beneficiaries who are admitted to SNF units may be experiencing fatigue or pain associated with their illness. They may not be able to participate in therapy to the fullest extent of their ability by the day 5 mark. Section T allows nursing facilities, through the educated opinion of their licensed therapists, to more accurately show the level of therapy that a patient will receive by day 15. This section allows facilities to better meet the beneficiaries' needs by allowing them rest that is clinically necessary, then proceeding with the level of therapy that is clinically necessary. Section T allows the patient to proceed at their individual level of tolerance. Therefore, it is my opinion that Section T allows nursing facilities to better reflect the actual care being given to a beneficiary.

Adequate access to care is very important to our beneficiaries. I am concerned that if these considerations are made into proposals beneficiary access may be affected. My rationale for this concern is that many small long-term care facilities would be unable to offset the cost of accepting a resident who was unable to participate in a rigorous rehab program for the first week of their stay. This may lead to some medically fragile beneficiaries having difficulty being placed in a SNF unit.

Thank you for your consideration of my comments.

Sincerely,

Beckie Lovell RN

Beckie Lovell, RN
SNF MDS Coordinator
Case Manager

15-H

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Fulfillment serving others

July 07, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS--1282—P
P.O. Box 8011
Baltimore, MD 21244-8011

To Whom It May Concern:

Subject: Comments on proposed changes to FY 2006 SNF PPS rule

Demographics: Our Skilled Nursing Facility at Phelps County Regional Medical Center in Rolla, Missouri is a twenty-bed hospital-based SNF unit.

Many persons are admitted for care of extensive wounds, e.g., Stage 3 & 4 pressure ulcers, non-closure of surgical wound (presenting wound is deep and/or wide) and wounds that have developed a sinus track. Wound treatment utilizes expensive modalities, require care by a certified wound/ostomy nurse and a lengthy SNF stay. Modalities include one or all of the following over the course of their treatment:

- Wound Vac with vac changed every 1-3 days (Wound vac & supplies are expensive)
- Sterile larvae therapy
- High cost topical and IV medications
- Large quantities of special dressings
- Direct care by a Wound/ostomy Nurse (usually 1-1 ½ hours with each dressing change)

A consolidated billing exclusion should be available for a SNF resident receiving one or more of the above stated treatment modalities. The MDS does not capture extensive and expensive wound care and treatment for these persons.

Thank you for consideration of this issue. Attached pictures of recent cases were healed at discharge.

Sincerely,

Sharon Riestis, RN BSN

Sharon Riestis, RN, BSN
MDS Coordinator

abdomen

lower leg

masectomy

cardiac cath site

116-H

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July 8, 2005

Attention: CMS–1282-P

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

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

Dear Dr. McClellan:

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

Qualifying 3-day Inpatient Hospital Stay for SNF Coverage

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

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

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

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

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

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

Finally, there appears no appreciation in this interpretation for the appropriate needs of the beneficiary, even within the context of the statutory requirement. We note that in your recent letter to House Ways and Means Chair Bill Thomas, you observe that "providers who have good ideas and want to take action to improve quality of care find that Medicare's payment systems do not provide them with the resources and flexibility to do so."

We would welcome the opportunity to visit with you to discuss these and other current practices that distinguish the practice of medicine during an observational day as being at least equal to, if not greater than, the intensity of inpatient care services. Please do not hesitate to contact Barbara Marone, ACEP's Federal Affairs Director at (202) 728-0610 ext. 3017 if you have any questions about our comments.

Sincerely yours,

Robert E. Suter, DO, MHA, FACEP
President

17-H

BRIDGEWATER
RETIREMENT COMMUNITY

July 8, 2005

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1282-P
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

In response to CMS-1282-P regarding proposed changes to Medicare Skilled Care rules and RUG rates, we would like to express some concerns related to the proposed elimination of the 5-day PPS assessment grace days.

Our facility has an average daily SNF census of approximately 10 residents, most of which are rehab driven. These patients require 5 days of therapy per week to recover, depending on the surgery and their post-op condition. Many of these cases have some weight bearing limitation for several days, are generally very tired upon admission and in considerable post-op pain. The condition of these residents upon admission makes them slow to tolerate higher therapy levels within the first 1-3 days.

In these rehab cases we have to use day 7 or 8 for the 5-day PPS assessment reference date to get reimbursed for the higher levels of therapy we ultimately provide during the first 14 day payment period. Otherwise, we must project through PPS assessment section T to RUG rehab high. If CMS withdraws the use of grace days on the 5 day PPS assessment and/or the section T projection, we will be required to bill for a lower RUGS score that does not adequately reflect the services we are providing.

Although, these problems do not exist in every case, we feel that the flexibility provided by the grace days is crucial in the proper matching of reimbursement with actual services provided. Accordingly, we feel that the elimination of the 5 day assessment grace days would result in reimbursements that would be inadequate to support the amount of services required by our residents. We thank you for your consideration of our concerns regarding this matter.

Sincerely,

Paul Hoyt, President
Bridgewater Retirement Community

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Affiliated with the Church of the Brethren / Operated by Bridgewater HealthCare, Inc.

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July 8, 2005

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

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

It is the mission of the Citizen's Memorial Health Care Foundation to support and assist Citizens Memorial Hospital in providing superior quality health care and related community health improvement services. Within our organization we have 5 Skilled Nursing Facilities and 1 Residential Care Facility. It is our responsibility to assure our residents get the most they can out of the services we provide, while working within the rules and regulations set forth for us. We believe our experience gives us a unique perspective on the practical impacts of the proposed changes.

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

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

Look-Back Period:

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

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

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

The RUG categories that will be affected to the greatest extent will be Extensive Services. It should be a matter of record that the most common defining service during the hospital stay that creates the SE category at the sub-acute level is IV medications. Many Medicare Part A eligible patients, who are admitted to a hospital (either through the ER or with a planned admission), have an IV started in the hospital. By not being able to utilize the look-back period, it appears that patients transferred to skilled nursing

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facilities will not be able to appropriately utilize one of the proposed new upper nine RUG-53 groups due to the lack of accessible data to properly code the patient into an extensive services level of care along with rehab therapy minutes and activities and daily living.

Many patients are admitted to the SNF mere hours after IV has been discontinued at the hospital. If the IV was, for example, to deliver chemotherapy, antibiotic therapy, heparin therapy, or blood transfusions, the patient will require a significant level of skilled nursing care for monitoring and treatment of symptoms associated with the causative medical condition. As it currently stands, the sickest of elderly patients are those in the first week after admission following a hospitalization for infections, chronic disease exacerbations (Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Cancer, etc.) and surgeries. These patients also debilitate quickly under those circumstances and may benefit from rehabilitation service but often are not able to participate in any meaningful therapy program within the first week to 10 days at the SNF. If the hospital look-back for IV meds is not allowed, it is possible the sickest patients will not have an appropriate RUG pathway to care.

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

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

The analysis cited in the proposed rule contends that the addition of nine new categories that combine Rehabilitation and Extensive services improves the predictive power of the RUG-III model. However, revising the RAI Manual to only include special treatments and procedures furnished by the SNF would significantly reduce the number of residents that would be classified into the Extensive Services category. Adding nine new RUG-III

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categories that combine Extensive Services with Rehabilitation, when patients would not be able to qualify for Extensive services, would seem to defeat the purpose of the RUG refinements and undermine the predictive power of the new RUG-53 model because many patients presently qualifying as Extensive Services would not be classified into the new levels (nor the present Extensive Services categories)/

Decrease or Elimination of the Grace Period:

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

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

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

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

Discharges from the hospital setting are not under the control of the SNF. It is the experience of the many SNFs, that many hospitals are prone to discharge patients on

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Fridays (typically in the afternoon). Regardless of the day of discharge, patients usually arrive at the SNF after 1:00 P.M. It is inappropriate to expect the new Medicare Part A patient to be able to tolerate all assessments required by the SNF nursing and rehabilitation therapy staff within the first few hours of admission to the SNF. The ambulance ride alone, often 30 minutes or more to the SNF (especially in a rural setting), can be a traumatic experience for the patient.

Most patients are not physically able to appropriately participate in an effective rehabilitation therapy evaluation on the afternoon of the admission to the SNF. In many facilities, rehabilitation therapy services are often not available seven days per week, thus patients cannot be evaluated for rehab therapy needs until the Monday following the "common Friday afternoon admission." Thus, if grace days are eliminated, the average days that can be included in the assessment reference window for rehab therapy will be two(2). This will inappropriately restrict the Medicare beneficiary's access to the Medicare Part A covered benefits (especially for rural Medicare Part A patients where therapist availability is even more limited).

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

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

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

Elimination of Projected Therapy Minutes

Elimination of the projection of anticipated therapy services during the five-day PPS assessment could negatively affect the quality of services and the benefits derived by the patients. Elimination could result in inappropriate incentives to either provide too much therapy too soon or delay therapy beyond when it would be best initiated for the patient's health.

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

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

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

By eliminating the ability to capture ordered and scheduled therapy services, there may be a tendency for providers to hasten to provide therapy services prematurely or at a level that is too rigorous for the individual's health status. On the other hand, if starting therapy early is not possible, there may be an incentive to forgo or at least postpone therapy services that could be very beneficial to improving a patient's function. In either case, there is an incentive to schedule the onset of therapy services based upon whether the provider will be paid at a rehab8litaion level, rather than what is the most appropriate for the beneficiary's care.

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

Qualifying Three-Day Inpatient Hospital Stay Requirement

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

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

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

Allowing observation days to count toward the required three-day hospital stay will require a change to the "common Working File" (CWF) because even though hospitals

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

Since the implementation of SNF PPS, there have been situations when SNF's have inadvertently co8unted an observation stay period as part of an acute care inpatient admission, resulting in a non-qualifying three midnight acute period. Counting observation midnights will assist with assuring appropriate payment for subsequent post-acute care and will not compromise services for the beneficiary. We appreciate CMS's consideration for this proposed change.

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

Summary

Generally, the SNF PPS program has allowed Medicare Part A patients to continue to receive quality care, while reducing costs and risk to the Medicare Trust Fund. We believe strongly that the proposed changes in the look-back period, use of grace days, and projecting therapy minutes would be very damaging to the SNF's ability to provide the quality post- acute care for Medicare Part A patients desired by all. Beneficiaries have earned the right tot utilize the Medicare program through their payment of payroll taxes

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throughout their work lives. The proposed RAI Manual changes could be damaging to many Medicare Part A patients (especially those living in rural communities) by potentially limiting access to coverage and services. The proposed changes could result in increased costs through increased re-hospitalizations and less rehabilitated SNF population ultimately requiring more, not less, services.

We respectfully submit our comments and appreciate your consideration when deciding on the proposed changes. Should you have any questions or if we can be of further assistance, please feel free to contact Mr. Tim Francka, Administrative Director of Long Term Care, Citizens Memorial HealthCare at 417-326-3000.

Sincerely,

Tim Francka
Administrative Director Long Term Care
Citizens Memorial Health Care

By cjs

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The Alliance For Quality Nursing Home Care

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July 12, 2005

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

Re: Comments of the ALLIANCE FOR QUALITY NURSING HOME CARE on the proposed rule on the Medicare Prospective Payment System for Skilled Nursing Facilities for FY 2006
70 Federal Register 20070, May 19, 2005 (CMS-1282-P)

Dear Dr. McClellan:

The Alliance for Quality Nursing Home Care welcomes this opportunity to comment on the proposed rule captioned above that would adopt changes to the Medicare prospective payment system for skilled nursing facilities for FY 2006. The Alliance is an organization representing large, nation-wide chains of nursing facilities, and several regional chains.[1] The purpose of the Alliance is to ensure that Federal regulatory policy does not hinder the ability of nursing facilities to provide the high quality and clinically proper care required by patients. To this end, the Alliance is respectfully submitting these comments to the proposed rule.

The most important matters presented by the proposed rule concern the market baskets used by CMS in various payment systems, CMS' development of cost indices and the resulting payment rates; the Minimum Data Set, grace period, and look back issues; and proposals on a uniform post acute assessment.

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[1] **The membership of the Alliance includes: Advocat Inc., Cypress Healthcare, Direct Supply, Inc., EDG Partners, LLC, Extendicare, Inc., Genesis Healthcare Corporation, Harborside Healthcare, HCR Manor Care Corp., Kindred Healthcare, Medical Facilities of America, NHS Management, LLC, SavaSeniorCare, Sea Crest Health Care Management, LLC, Shoreline Healthcare Management, Sun Healthcare Group, Inc., Tamarac Administrative Services, Tandem Health Care, Inc., Trans Healthcare Inc., UHS-Pruitt Corporation**

The Alliance is also concerned about multiple geographic wage index adjustments and pay-for-performance issues. Finally, we wish to make comments as well on the issues of concurrent therapy, the 3-day stay requirement, and exclusions from the PPS.

Initial comment – in general

- ***Recommendation: The drastic reduction in aggregate Medicare reimbursement for SNFs must be alleviated***

Medicare reimbursement will be $450 million dollars less than it would have been if the nursing facility community had been kept at the 2005 rate for all of 2006. The proposed rates will result in more than $7 billion less in Medicare nursing facility reimbursement in 2006 through 2015 than there would have been if the 2006 per patient day expenditures were kept at the 2005 levels.

The Alliance companies are prepared to accept a reduction in 2006 reimbursement. However, the reductions in the proposed rule represent too drastic a cut. They may result in a repeat of the financial shock that the long term care community felt after the implementation of the Prospective Payment System in 1998/99. The nursing facility community is an integral part of the continuity of care system in the United States and one that we can not afford to have suffer a systemic breakdown. Slashing the reimbursement rate so deeply will send shock waves through our health care delivery system, causing unintended problems.

For this reason, although the Alliance will comment in support of the concept of RUG refinement, we believe that the impact of this particular proposal needs to be thoroughly re-evaluated. A more equitable proposal would have had the per diem rate for 2005 carry forward with no change into the first quarter of 2006. The implementation of the new RUG-53 should then be built in a budget-neutral way against this rate. This would allow stability to the nursing facility community's business model by removing the increase in October of 2005 that is followed by a huge decrease in January of 2006. The following comments provide a variety of approaches to achieving a stable per diem from 2005 to 2006.

The Skilled Nursing Facility Market Basket Index

[§ I.G., p. 29074]
[§ II., p. 29074]
[§ III, p. 29097]

Methodological Changes that Would Result in More Accurate and Representative Market Basket [MB] Update Factor for Medicare SNFs for Prescription Drug Costs

- ***Recommendation: The SNF MB should be restated to eliminate outdated data and include current cost data. It should use the most updated cost data available.***

- ***Recommendation: The SNF MB should be revised to reflect industry data and CMS' own data, that prescription drug costs represent more than 10 percent of SNF costs***

- ***Recommendation: The proportion of costs attributed to prescription drugs in the MB should be derived from SNF cost reports alone***

The SNF Market Basket (MB) index factor proposed in the May 19, 2005 NPRM is inadequate because it is based on outdated, inaccurate, and non-representative data regarding prescription drug expenditures. The data underlying to SNF Market Basket are flawed in three important ways.

- First, the MB is based on outdated data. The SNF MB index is partially based on an updated distribution of costs that begin with 1997 data. Data from 1997 do not reflect the dynamic changes in SNF costs that have occurred between 1997 and 2005.

- Second, the MB is based on inaccurate data that do not reflect current SNF costs. In particular, CMS's own published data show that prescription drug charges, and subsequently costs as a proportion of overall Medicare patient costs, are far above the 3.0 percent that the MB assumes. The published CMS and industry data correctly estimate that prescription drug costs represent more that 10 percent of nursing facility costs.[2]

- And third, the MB calculation is based on non-representative data. The proportion of costs attributable to prescription drugs contained in the MB is derived from a combination of nursing facility and hospital cost reports. The quantitative and qualitative differences in the data contained in these two reports are significant. For example, hospital cost reports are based on revenue center allocations and codes where hospitals have considerable discretion in allocating costs across revenue centers. Free-standing SNFs do not have this flexibility, resulting in profoundly non-representative data.

The net result of the outdated, inaccurate, and non-representative data is that the MB significantly understates real SNF costs.

The current Market Basket calculation assumes that prescription drugs represent 3 percent of the total costs of nursing facility care for beneficiaries in Medicare SNF stays. As one national chain pharmaceutical manager put it, "Pharmaceutical costs as a percent of total per diem costs were more than 3 percent of total costs 15 years ago." CMS and industry data clearly show that the correct proportion that pharmaceuticals represent of

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[2] ***Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1999, 2000, 2001 and 2002.*** **Table 42, Covered Admissions and Total Charges for Medicare Skilled Nursing Facility Admissions, by Covered Days of Care and Type of Service.**

total facility Medicare costs is on the order of 10 to 14 percent, not 3 percent as portrayed in the market basket calculations. Table 1 shows the published charge data from the CMS *Health Care Financing Review* for 1997 through 2001.

Table 1
Medicare Skilled Nursing Facility Charges by Type of Service
(1997 through 2001)

	Charges in Thousands					Percent of Charges				
	1997	1998	1999	2000	2001	1997	1998	1999	2000	2001
All Services	*$23,596,832*	*$22,803,521*	*$18,417,408*	*$18,434,442*	*$20,548,977*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*
Accomodations	$9,454,126	$9,270,098	$9,342,422	$9,595,767	$10,616,622	40.1%	40.7%	50.7%	52.1%	51.7%
Ancillaries	*$14,114,784*	*$13,514,544*	*$9,075,212*	*$8,838,892*	*$9,932,555*	*59.8%*	*59.3%*	*49.3%*	*47.9%*	*48.3%*
Pharmacy	$2,700,274	$2,798,071	$2,381,909	$2,446,438	$2,794,460	11.4%	12.3%	12.9%	13.3%	13.6%
Laboratory	$488,623	$486,631	$509,298	$513,525	$573,442	2.1%	2.1%	2.8%	2.8%	2.8%
Radiology	$199,878	$201,140	$180,982	$171,248	$182,212	0.8%	0.9%	1.0%	0.9%	0.9%
Supply	$876,498	$835,887	$689,698	$623,985	$677,812	3.7%	3.7%	3.7%	3.4%	3.3%
Inhalation Therapy	$1,435,692	$1,216,053	$463,390	$384,174	$399,910	6.1%	5.3%	2.5%	2.1%	1.9%
Rehabilitation	$7,205,822	$6,868,076	$4,659,669	$4,535,331	$5,132,603	30.5%	30.1%	25.3%	24.6%	25.0%
Other	$1,207,996	$1,108,687	$189,265	$164,190	$172,115	5.1%	4.9%	1.0%	0.9%	0.8%

Source: Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1999, 2000, 2001 and 2002. Table 42, Covered Admissions and Total Charges for Medicare Skilled Nursing Facility Admissions, by Covered Days of Care and Type of Service.

Note that the data in Table 1 are charge data. The applicable cost to charge ratio and discussions with industry cost report experts suggest that the costs for these charges are in excess of 10 percent, not 3 percent.

Correcting the Underestimate

- ***Recommendation: The MB should be recalculated retrospectively to the beginning of the SNF PPS***

We strongly believe that CMS should retrospectively recalculate the MB using its own data. This recalculation would result in an increase of at least 3.2 percent or more in each of the RUG 53 weights for 2006. The correction calculation should be made retrospectively to the beginning of the PPS system, i.e., 1998. The precedent for this retrospective calculation was set by CMS in its adjustment to the MB forecasting error, where an identical correction was made retrospectively.

An issue relating to our requested change to the NPRM is whether CMS will allow the retrospective adjustment to cause the MB weights to exceed 100 percent, or whether CMS will feel it necessary for the weights to add to 100 percent. Allowing the weights to exceed 100 percent will cause the MB to increase even more than our estimate of a minimum adjustment of 3.2 percent. Thus, CMS might wish to force the sum of the weights to 100 percent. Our analysis shows that the reductions in weights necessary to accommodate an increase in the prescription drug rate should by made by reducing the non-labor component weights in the MB.

Professional Liability

> ***Recommendation: CMS should study the effect of adding a separate weight for professional liability costs. CMS should work with the SNF industry to determine how the weight should be calculated, given the various financing arrangements SNFs have, and to develop an appropriate price index.***

As discussed below, more frequent updating of the market basket weights is crucial to accounting more accurately for changes in the cost of providing services for SNFs. The current SNF market basket does not contain a measure for the price change of purchasing professional liability insurance or of self-insuring, which is a result of CMS's use of old data and infrequent re-weighting. The last time the market basket was revised, in 2001 using 1997 cost report data, CMS decided not to include a liability insurance input because they lacked sufficient data to accurately determine SNF's insurance costs. The professional liability insurance market has been volatile in the past several years, and the large cost increases SNFs have faced in purchasing liability insurance or reinsurance (when self-insuring for professional liability costs) have been well-documented. For example, a study by Aon Risk Consultants, Inc., found that nursing home insurance premiums increased by 130% between 2000 and 2001 and by 143% between 2001 and 2002. Because there is no weight for professional liability costs and therefore no index to measure price changes for that weight, the current market basket does not capture these cost increases.

CMS Should Re-weight the Market Basket More Frequently

> ➢ ***Recommendation: The MB should be revised and re-weighted with greater frequency – on the same schedule as the hospital MB.***

The basis for the 2006 proposed market basket update of 3.0 % comes from, for the most part, 1997 cost report data. The 1997 cost reports, plus some other data sources, are the source of the weights by which changes in the prices of items SNFs purchase are multiplied each year to calculate the market basket update. Since 1997, SNFs have made major changes in their operations, such as responding to the implementation of the prospective payment system and adopting new technologies. CMS acknowledges this in this NPRM, stating: "it became clear that the introduction of the SNF PPS and SNF consolidated billing had caused changes in facility practice patterns and billing. Some of these changes could also have been related to the use of a national database and to changing industry practices..." (70 Federal Register 29075). In addition, SNFs have been responding to marketplace changes such as self-funding for professional liability. The assignment of weights within the market basket does not reflect these changes.

It is imperative for the market basket to be re-weighted on a regular basis, so that the market basket accurately reflects the type and level of expenditures in SNFs and so that

the impact of price changes of inputs used in calculating the update actually reflects those inputs' relative importance.

The Congress recently instructed CMS to study the frequency with which a market basket should be updated in order to be most accurate.[3] The statute requires CMS to re-weight the hospital market basket immediately and to establish a set frequency for revising and re-weighting it. The statute instructs CMS to publish an explanation of the reasons the agency chose that frequency. It is very important that CMS undertake this study, because the current frequency with which the market baskets are re-weighted appears ad hoc and based on the availability of outside data sources, rather than on considerations of mathematical accuracy. Even though CMS has been charged with studying the hospital market basket, the results will likely be applicable to the SNF market basket since many of the inputs and their weights are similar.

We urge CMS to complete the study of the how frequently the hospital market basket should be updated, and to update the SNF market basket weights with the same frequency using submitted cost report data. We believe that this will improve the validity of the SNF market basket methodology and the increase the accuracy of the market basket updates.

CMS Should Use a Different Price Index for SNF Wages

> ➢ ***Recommendation: CMS should use a SNF-specific wage price index calculated from data gathered from Medicare-participating facilities.***

Another major concern with the SNF market basket as currently conceived is the use of the Employment Cost Index (ECI) for Private Nursing Homes, the price index used to calculate price level changes for nursing home employees. This price proxy includes wage price data for entities which are not SNFs and which do not receive payments under the Medicare program; SNF payment levels are being based on wage changes in non-SNF homes. The ECI is a broad measure the nursing home industry wage changes, but is not specific to SNFs. There is evidence that wages in SNFs are growing faster than in the industry as a whole. CMS should use a SNF-specific wage price index calculated from data gathered from Medicare-participating facilities.

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

- Nursing facilities (This category contains not only skilled nursing facilities, but also other facilities that would not qualify as Medicare SNFs, such as facilities which, although they provide skilled care (like long-term care services), do not provide post-acute care.)

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[3] **See §404 of Pub.L. No. 108-173, 42 U.S.C. §1395ww note.**

- Inpatient care facilities and mental retardation facilities,
- Community care homes, and
- Other homes, such as personal and domiciliary care homes.

Common sense suggests that the different types of facilities listed above would employ distinct mixes of workers, i.e., different occupational mix. For example, SNFs handle patients discharged from hospitals, needing constant nursing care, rehabilitation, and other skilled nursing services. It is unlikely that the other types of "Private Nursing Homes" would provide that kind of care and thus would not employ the same kind and number of skilled medical workers.

It is unlikely that the ECI is reflective of price changes in SNFs because BLS data show that SNFs employ more skilled medical staff than other types of nursing facilities and that overall, the wages of medical staff are growing faster than the wages of other staff. SNFs employ about twice as many registered nurses, licensed professional nurses, and nurse aides (as a percent of total workers) as other nursing facilities, according to the Occupational Employment Statistics survey (OES).[4]

Table 2
2003 Occupational Mix, by Facility Subcategory, OES

	Nursing Facilities[5]	Intermediate Care Facilities	Community Care Facilities	Other Care Facilities
RNs	7.73%	2.06%	3.94%	1.29%
LPNs	11.28%	2.21%	5.56%	0.83%
Nurse Aides	37.93%	6.45%	20.08%	1.64%
All Health Workers	64.45%	34.29%	45.84%	13.29%

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

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

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

Table 3
Wage Growth from 2002 to 2003, OES Data

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

As the table below shows, the OES data for nursing facilities, the category that includes the SNFs, show that wage changes in nursing facilities more closely resembled changes in the Hospital ECI than the ECI for Private Nursing Homes last year, indicating that the wage change profile of nursing facilities more closely resembles that of hospitals than it does of all the facilities included in the nursing home ECI.[6]

Table 4
Change in Wages from 2003 to 2004 across Sites of Care

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

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

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

We strongly recommend that CMS evaluate other options than the ECI for Private Nursing Homes in order to measure changes in the price of wages and salaries for SNFs. Specifically, we believe CMS should engage in a data collection effort aimed at collecting SNF-specific labor data for the purposes of creating a price proxy for labor costs in Medicare SNFs. The annual cost reports could be adapted for this purpose under existing authority.

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

Proposed Refinements to the Case-Mix Classification System

Technical Adjustment of Nursing and Therapy Indices

> ➢ ***Recommendation: Increase the nursing weighted index percentage and the therapy weighted index percentage by 5 percentage points each***

As articulated in the preamble of the May 12, 1998 interim final SNF PPS rules (p. 26261, Federal Register, May 12, 1998), "The principal goal of case-mix measurement is to identify patient characteristics associated with measured resource use."

The foundation of the SNF PPS payment structure is rooted in two independent steps -- staff time measurement studies and salary ratios among worker categories. These converge to form the economic case mix base of the process.

With regard to the staff time measurement studies, a number of methodological flaws have been identified. Data were collected from a small number of facilities (fewer than 1% of Medicare participating SNFs). Data were drawn using a "sample of convenience," which was neither random nor representative. Participation was by self-selection. Two rural states, Maine and South Dakota, were over-represented; hospital-based facilities were significantly under-represented. Concerns have been raised on the appropriateness of the observation period and on the methodological rigor of actual reporting. The failures of the time studies to address non-therapy ancillary services are well documented. Even CMS acknowledges the weaknesses of this important building block of the rate structure and the agency is in the process of developing new contract specifications to revise and update the staff time studies in the coming year.

While time measurement studies form the framework for case mixing services, the work category ratios are the drivers of rates. The fact that the SNF PPS is built upon historic patterns makes it difficult to pay for upgrading staff. Concerns have been raised that the original rules were based on the low-range of compensation scales, and adjustments necessary to compensate for the raise in the Federal minimum wage standards subsequent to the base year are not included in the economic assumptions. The assumptions used locked in the pool of dollars available to secure staffing.

The imperfections of the original research design are magnified by time. Absent updated staff time measurement studies, CMS is forced to rely on data that are both flawed and outdated. The two case mix indices tables published on the CMS website on June 26, 2005, reflect decade old relationships, not current service delivery relationships, between the staffing mix and direct care worker compensation ratios. CMS's own *Report to Congress on the Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* offers an anthology of data affirming that care patterns have changed, compensation for care givers has changed, and the snapshot captured in the early-to-mid-1990s is not reflective of today's nursing facility staffing and compensation.

Skilled nursing facilities are competing for direct care workers – RNs, LPNs, Certified Nursing Assistants, and rehabilitation professionals -- in a very competitive marketplace. Not only have the mix and number of direct care workers changed in the decade, the compensation relationships have also changed. Just as concerns about the representativeness of the SNF market basket led to the rebasing and recalibration of the market index, updates are needed to assure that staff time measurements and compensation relationships are reflective of current market conditions and patterns of care.

Accepting that time does not permit an updating of the time studies, the simplest fix would be for CMS to make an upward adjustment of each of the national weighted indices (nursing and rehabilitation) by 5 percentage points. This interim correction will help establish a realistic base for future year revisions based upon updated time studies and more accurate compensation measures.

Increase Case-Mix Adjustment to Compensate Appropriately for Non-therapy Ancillaries

- ***Recommendation: Add an additional 8% to the proposed 8.85% non-therapy ancillary adjustment factor***

On p. 29078 of the proposed rule (Federal Register, May 19, 2005), CMS proposes to provide for an additional adjustment to the nursing component of the case mix weights for all RUG-53 groups. The preamble text explains that this adjustment is proposed better to account for non-therapy ancillary variability. The agency indicates this action is being taken under the authority of section 1888(e)(4)(G)(i) of the Act to establish an "appropriate adjustment to account for case mix ."

We strongly endorse the exercise of this authority. Obviously, given the variability of non-therapy ancillaries and the failures of the initial SNF PPS methodology to compensate adequately for these important care services, it is appropriate for CMS to adjust the rate structure in a manner that reimburses non-therapy ancillaries adequately.

As explained in the preamble, the initial 8.4% adjustment (slightly revised to 8.85% based on the revised data posted on the CMS website on June 26, 2005) reflects CMS' estimates of the value of an outlier policy under the Inpatient Rehabilitation Facility (IRF) PPS system. CMS points out that "For the purposes of this refinement, our calculations employed a comparable funding level that could be targeted toward payment of non-therapy ancillaries."

Conceptually, this linkage to compensate for adjustments reflected in another post-acute setting appears logical. Unfortunately, the analysis performed by CMS did not carry forward to adjust the comparable "outlier" pool further to reflect the differences in explanatory power between the methodologies used in the two payment systems. Data developed by the Medicare Prospective Payment Commission and verified by the Lewin Group affirm that the IRF PPS has ten times more explanatory power than the SNF RUG

approach. There is greater clustering of costs in the IRF payment system (adjusted R-square exceeds 50%) than in the SNF PPS Resource Utilization Groups (adjusted R-square less than 5%).

Muse & Associates modeling of the range of adjustments necessary to reflect non-therapy ancillary costs adequately, affirm the need to add an additional 8% to the proposed 8.85% adjustment. The Muse analysis supports an adjustment factor of 16.85%.[7]

Adjust to Account Better for Non-Therapy Ancillary Variability

> ➢ ***Recommendation: The additional aggregate payments should be included in the unadjusted nursing case mix component of the rate rather than through an adjustment to the nursing index.***

The proposed rule includes an adjustment to the case-mix weights for all 53 groups in order better to account for non-therapy ancillary variability.[8] We applaud CMS for the acknowledgment that the current RUG baseline payments do not adequately account for the cost of non-therapy ancillary services. Congress also acknowledged this fact with the inclusion of add-ons through the Balanced Budget Act of 1997 (BBRA) and the Benefits Improvement and Protection Act (BIPA) provisions.[9]

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

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

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[7] **Muse & Associates calculated the adjusted index for each RUG as follows: multiply the unadjusted nursing index by one plus the adjustment factor of 3.05%, and then multiply the product by one plus the budget neutrality factor of 8.85%. Then multiply the therapy weight by one plus the adjustment factor of 20.75%. Repeat this for each RUG. This inflates the budget neutrality factor to 16.85%.**

[8] **70 Federal Register 29079.**

[9] **BBRA, Pub. L. No. 105-33, Section 103 and BIPA, Pub. L. No. 106-554, Section 313.**

In addition, including the amount in the base rate rather than in the nursing index would eliminate the need for CMS to continually assure that the appropriate adjustment factor is included in the nursing index at such time that the index is re-weighted or recalibrated through updated time studies or other factors.

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

Implementation Issues

Equal Distribution of Payments throughout the Fiscal Year [p. 29081]

> ➢ ***Recommendation - In order to assure a more consistent and equitable allocation of the change in the payments rates, CMS should adjust the payment rates to result in the equalization of the per diem payments in each fiscal quarter based upon the weighted average for the fiscal year.***

Under the current proposal, CMS will reduce per diem payments effective January 1, 2006, upon the implementation of the RUG-53 refinement. We believe that under the authority granted to the Secretary in §1888(e)(4)(E)(ii) of the Social Security Act, CMS must establish average payment rates for the entire fiscal year. The transition to a new payment approach, i.e. RUG-53, does not in itself require the Secretary to establish a differential in rates during the year. Therefore, we believe that it is within the Secretary's authority, even with the net reduction in payment due to the proposed RUG refinement, to spread the effect over the entire fiscal year. We provide two options, based on alternative methodologies for the inclusion of the adjustment to better account for variation in non-therapy ancillaries.

Option 1

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

Option 2

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

indexes should be adjusted by an appropriate factor to assure that the aggregate payment rates are averaged throughout the fiscal year. Table 5 illustrates an example of the calculation of the adjustment factors to be applied.

Table 5
Sample estimate of adjusted annual rate

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

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

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

Correction to Budget Neutrality Adjustment

> ➢ ***Recommendation: CMS should adjust the aggregate rate by 1% to include $3.00 per patient day in the average payment.***

In order to assure that the baseline total aggregate payments were consistent between the RUG-44 methodology and the revised RUG-53 methodology as proposed, CMS applied a budget neutrality adjustment to the payment formula. While the goal of moving to the new payment model is to improve the accuracy of payments to heavy-care patients, CMS must guard against unintended consequences. It is our belief that the underlying assumptions in CMS's estimates result in an understatement in payments. The underestimate results from the use of actuarial estimates instead of actual payment simulations.

The difference in our estimation is approximately $3.00 per patient day or slightly less than 1% of the total average rate. While unintended, any shortfall in payments has the potential to compromise the delivery of quality care to Medicare beneficiaries. In order to correct this issue, **we recommend that CMS should adjust the aggregate rate by 1% to include $3.00 per patient day to the average payment.**

Implementation of the Revised Labor Market Areas
[p. 29094 – 29095]

> ***Recommendation: CMS should implement a phase-in of the transition from the MSA to the CBSA based labor market index. CMS should also include a "rural floor."***
>
> ***Recommendation: CMS should develop a SNF wage index.***

CMS proposes "to adopt for the SNF PPS the new CBSA-based labor market area definitions beginning with the 2006 SNF PPS rate year without a transition period and without a hold harmless policy." CMS bases this approach on its analysis that only "a minimal number of SNFs would experience a decrease of more than 5 percent in the wage index." The new labor market designations for CY 2006 would be effective January 1, 2006. [p. 29095.]

The impact of the changes to the Area Wage Index in this NPRM are intended to be budget neutral. However, individual facilities could see dramatic swings in reimbursement depending on their location. Less then 5 percent of all facilities will face a change in reimbursement of greater then 7 percent. The NPRM states that "A minimum number of SNFs would experience a decrease of more than 5 percent." [p. 29095.]

The Alliance believes that special provisions <u>are</u> necessary to deal with SNFs whose per diem rates are extremely adversely affected solely by the adoption of OMB's new labor market designations. While CMS may not favor a hold harmless policy or transition period provision, some relief must be made available for SNFs that would otherwise be placed in a precarious fiscal position by the new per diem rates resulting from the adoption of the new labor market areas.

<u>Background</u>

The Office of Management and Budget (OMB) defines Metropolitan Statistical Areas, Micropolitan Statistical Areas, Combined Statistical Areas, and New England City and Town Areas for use in Federal statistical activities. OMB issues periodic updates of the areas between decennial censuses based on Census Bureau data. New metropolitan and micropolitan statistical area definitions were announced by OMB on June 6, 2003, based on application of the 2000 standards to Census 2000 data. Metropolitan and Micropolitan Statistical Areas are collectively referred to as "Core-Based Statistical Areas."

CMS used the Core-Based Statistical Areas to redefine the wage index in the NPRM. The base wage rates are published in the NPRM (Tables 2 and 3). For each RUG category, there are assorted indices. The nursing component listed in Table 6 below is multiplied by the nursing index, the therapy component is multiplied by the therapy index, and the therapy non-case mix and the non-case mix components are applied to

the appropriate categories. The sum of these produces the base per diem reimbursement for each RUG. The Area Wage Index is then applied. The index is multiplied by 76.087 percent of the rate for that RUG. This methodology is designed to replicate the differences in the employers' cost of labor.

Although we agree that using the new CBSA categories issued by OMB makes possible the efficient inclusion of current data in the annual wage index calculations, we believe that CMS is wrong to minimize the adverse effect the new categories will have on many SNFs. First, the changes will be implemented in the context of an industry-wide reduction in Medicare SNF payments of $500 million for FY 2006. Thus, SNFs will already be subjected to actual reductions in payment rates compared with FY 2005. Second, the effective reductions, especially reductions of more than $50 per patient day, are concentrated within particular regions and ownership groups. Even if the aggregate effects of the new wage index are minimal overall, they will produce catastrophic results for individual companies and individual facilities. CMS should provide relief to prevent such outcomes. Third, if only "a very small number of SNFs (4 percent) would experience a decline of 5 percent or more in the wage index based on CBSA designations," [p. 29094, 3d column], it would be a relatively simple matter for CMS to fashion relief that would prevent serious harm to those SNFs, and the patients and communities they serve.

Table 6
Components of the Base Rate

	Nursing Case Mix	Therapy Case Mix	Therapy Non-case Mix	Non-case Mix
Urban	$137.44	$103.53	$13.63	$70.15
Rural	$131.30	$119.38	$14.56	$71.45

Nursing facilities in Albany, GA, for example, will experience a reduction of more than $58 in their per diem rate, solely as a result of the transition from the MSA-based wage index to the CBSA-based wage index. Similarly, the per diem rate for rural facilities in Vermont would fall by more than $51.

The logical remedy for this situation is for CMS to develop a Skilled Nursing Facility (SNF) Wage Index. This index would take into account the unique geographic factors that SNFs face in recruiting and retaining employees. Upon the development of this SNF Wage Index, CMS should create a phase-in period for any facilities that would face a dramatic change in rates due to the SNF Wage Index. This phase-in should pay special attention to those rural facilities that switch to an urban area as a result of the transition for the MSA Wage Index to the SNF Wage Index.

The authority for CMS to implement a wage index comes from section 1888(e)(4)(G)(ii) the Social Security Act. The requirement that CMS develop and implement a SNF Wage Index is in section 1888(e)(5). CMS has studied the issue and decided that the data in

existence are not adequate to develop a SNF Wage Index. They reiterated this position in the final rule for 2002.[10]

There is no doubt that the development and implementation of a SNF Wage Index would improve the accuracy of the resource allocation in the SNF sector of Medicare. CMS acknowledged this in the final rule 2004.[11] However, CMS continues to insist that they do not have the data to develop and implement a SNF Wage Index properly. Additionally, CMS' delay in developing and implementing a SNF Wage Index has prolonged the time during which facilities that believe they are improperly classified are limited in their ability to request reclassification.

The replacement of the MSA-based wage index with the CBSA wage index will have a dramatic localized impact on Medicare nursing facility reimbursement. We have compared the MSA-based wage index currently in place with the CBSA-based wage index in the Notice of Proposed Rule Making (NPRM)[12] and assessed how the proposed changes will impact Medicare nursing facility per diem reimbursement rates.

In order to limit the shock to individual facilities, we recommend a rural floor. The concept of the "rural floor" is not unknown to CMS. Section 4410 of BBA provides that for purposes of section 1886(d)(3)(E) of the Act, the area wage index applicable to hospitals in urban areas may not be less then the area wage index for hospitals in rural areas of the State. This same logic should be applied to SNFs.

Analysis

We compared the 2006 CBSA-based wage index published in the Proposed Rule with the existing MSA-based wage index vis-à-vis Medicare nursing facility reimbursement rates. We then compared both indices to the Medicare rate published in the NPRM. This allows us to measure the impact of the changes in the Area Wage Index exclusive of the Market Basket update.

Outliers

For many areas the proposed changes are minimal. However, in other areas there are dramatic differences. San Benito County in California is an interesting example. San Benito County's MSA-based wage index increases from 1.0297 in 2005 to 1.0639 in 2006. However, their CBSA-based wage index is 1.5125 in 2006. We estimate the impact of this change on base reimbursement to be approximately $100 per patient day. This increase is entirely due to the effect of switching from the MSA to the CBSA. Conversely, Imperial County, California faces a cut of more than $30 per patient day. Their 2005 MSA wage index is 1.0297 while their 2006 CBSA wage index is 0.8915. Additionally, Culpeper County, Virginia, faces a shift from an MSA-based wage index

[10] Federal Register Vol. 66, No. 147, July 31, 2001. p 39564 and 39579.
[11] Federal Register Vol. 68, No. 149, August 4, 2003. p 46046.
[12] Federal Register, May 19, 2005, pp.29070- 29162. 42 CFR Part 424, "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006."

of 1.097 in 2005, to a CBSA-based wage index of 0.8012 in 2006. This results in a reduction in reimbursement of $70 per patient day.

Our analyses concur with CMS' contention that the changes to the Area Wage Index included in this NPRM are budget neutral in the aggregate. That is not to say that some areas, as shown in the above examples, will not see dramatic swings in their reimbursement rates due to the changes to the Area Wage Index.

Most of the Area Wage Index reimbursement changes are due to the switch from an MSA to a CBSA based system. In the above mentioned counties, the rates would have changed much less dramatically if the 2006 MSA wage index had been used.

Winners and Losers

Tables 7 and 8 show the top ten winning and losing rural areas, respectively. Similarly, Tables 9 and 10 show the top 10 winning and losing urban areas, respectively.

Table 7
Rural States that Face the Biggest Rate Reductions Between 2005 and 2006

State	2005 Index	2006 Index	2005 Rate	2006 Rate	Difference Between 2005 Rate and 2006 Rate
Vermont	0.9375	0.7026	$275.81	$224.06	($51.76)
Idaho	0.8826	0.8045	$263.72	$246.51	($17.21)
Nevada	0.9833	0.9074	$285.90	$269.18	($16.72)
Utah	0.8843	0.8126	$264.09	$248.29	($15.80)
Georgia	0.8247	0.7666	$250.96	$238.16	($12.80)
North Dakota	0.7743	0.7268	$239.85	$229.39	($10.47)
Virginia	0.8480	0.8012	$256.09	$245.78	($10.31)
Nebraska	0.9035	0.8665	$268.32	$260.17	($8.15)
Arizona	0.9140	0.8777	$270.63	$262.64	($8.00)
West Virginia	0.8084	0.7725	$247.37	$239.46	($7.91)

Table 8
Rural States that Face the Biggest Rate Increases Between 2005 and 2006

State	2005 Index	2006 Index	2005 Rate	2006 Rate	Difference Between 2005 Rate and 2006 Rate
New Hampshire	0.9940	1.0677	$288.26	$304.50	$16.24
California	1.0297	1.0857	$296.13	$308.47	$12.34
Washington	1.0072	1.0458	$291.17	$299.67	$8.50
Alaska	1.1637	1.1990	$325.65	$333.43	$7.78
Connecticut	1.1586	1.1794	$324.53	$329.11	$4.58
Texas	0.7910	0.8077	$243.53	$247.21	$3.68
Montana	0.8701	0.8833	$260.96	$263.87	$2.91
Michigan	0.8741	0.8870	$261.84	$264.69	$2.84
Louisiana	0.7291	0.7418	$229.89	$232.69	$2.80
New Mexico	0.8529	0.8644	$257.17	$259.71	$2.53

Table 9
Urban Areas that Face the Biggest Rate Reductions Between 2005 and 2006

City	State	2005 Index	2006 Index	2005 Rate	2006 Rate	Difference Between 2005 Rate and 2006 Rate
Albany	GA	1.1266	0.8636	$320.11	$261.68	($58.43)
Madera	CA	1.0408	0.8721	$301.05	$263.57	($37.48)
Warren-Farmington Hills-Troy	MI	1.0817	0.9861	$310.14	$288.90	($21.24)
Warner Robins	GA	0.9596	0.8654	$283.01	$262.08	($20.93)
Napa	CA	1.3517	1.2656	$370.12	$350.99	($19.13)
Battle Creek	MI	1.0350	0.9510	$299.76	$281.10	($18.66)
Springfield	OH	0.9232	0.8404	$274.92	$256.53	($18.40)
Lebanon	PA	0.9286	0.8468	$276.12	$257.95	($18.17)
Albuquerque	NM	1.0485	0.9693	$302.76	$285.16	($17.60)
Vineland-Millville-Bridgeton	NJ	1.0573	0.9837	$304.72	$288.36	($16.35)

Table 10
Urban Areas that Face the Biggest Rate Increases Between 2005 and 2006

City	State	2005 Index	2006 Index	2005 Rate	2006 Rate	Difference Between 2005 Rate and 2006 Rate
Sacramento-Arden-Arcade-Roseville	CA.	0.9378	1.2973	$278.17	$358.03	$79.87
Grand Forks	ND-MN	0.9092	1.1516	$271.81	$325.67	$53.85
New York-Wayne-White Plains	NJ-NY	1.0923	1.3185	$312.49	$362.74	$50.25
Flagstaff	AZ	1.0611	1.2105	$305.56	$338.75	$33.19
Houston-Baytown-Sugar Land	TX	0.8525	1.0005	$259.22	$292.10	$32.88
Vallejo-Fairfield	CA	1.3517	1.4899	$370.12	$400.82	$30.70
Lexington-Fayette	KY	0.8053	0.9084	$248.73	$271.64	$22.90
Newark-Union	NJ-PA	1.1171	1.2195	$318.00	$340.75	$22.75
Santa Barbara-Santa Maria-Goleta	CA.	1.0771	1.1538	$309.11	$326.15	$17.04
Greenville	SC	0.9400	1.0165	$278.66	$295.65	$17.00

Proposed Refinements to the Case-Mix Classification System

MDS, grace period, and look back
[p. 29080]

MDS instructions; "look-back"

> ➢ *Recommendation:* **CMS should retain the 14-day "look-back" provision which yields the most realistic assignment of patients to appropriate payment categories.**

The MDS's 14-day "look-back" provision in the specific context of the SNF level of care presumption has both clinical and financial implications. The four items that CMS has focused on: IV medications, suctioning, tracheostomy care, and use of a ventilator/respirator, have significant clinical implications with respect to appropriate assessment, care planning, and delivery of care to our residents. CMS has commented 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. By revising the MDS instructions, CMS believes that there will be a reduction in SNF payments by better aligning them with services actually provided. Perhaps, clarification or revision to "presumption of coverage" might better suit CMS's intent by requiring there to have been assessment, care planning, and documentation of skilled services provided in the nursing facility from day of admission. Prior to implementing any changes, we suggest that CMS investigate clinical pathways for the most common admission diagnoses that have warranted those extensive services provided in the hospital.

Pneumonia is an excellent example of the need for the look-back period.

According to CMS's Resident Assessment Instrument (RAI) Manual Version 2.0, IV medications include any drug or biological (e.g., contrast material) given by IV push or drip through a central or peripheral port. The following treatment may be received by a nursing facility resident either at the facility, as a hospital outpatient or on an inpatient basis during the last 14 days.

Pneumonia is the second leading reason for hospitalization among Medicare beneficiaries, accounting for more than 600,000 Medicare hospitalizations yearly, and is the fifth leading cause of death among Americans older than 65 years. Timely administration of antibiotics to hospitalized patients with pneumonia has been associated with improved survival. Guidelines recommend antibiotic treatment within eight hours of arrival at a hospital. (JAMA, March 22, 2004) The optimal total duration of antibiotic therapy for Community Acquired Pneumonia (CAP) has not been defined in prospective studies. By convention, 10–14 days is the usual duration of therapy. Since about half the patients with CAP have respiratory symptoms at a 30-day follow-up, it is possible that longer therapy may be beneficial. In a series of studies, Ramirez and colleagues defined

criteria for switching from IV to oral antibiotics for treatment of patients with CAP. These include: two normal temperature readings on two occasions, eight hours apart, for previously febrile patients; WBC counts returning toward normal; subjective diminishment of cough; subjective diminishment of shortness of breath. (Thomas J. Marrie, October 2000)

The average hospitalization for elderly residents with pneumonia is seven days. Those residents transferred to a nursing facility will require skilled nursing assessment, observation and management to prevent recurrence/re-hospitalization. The 14-day IV look back period provides identification of IV antibiotic administration and required diagnosis for subsequent assessment and care planning of needed skilled nursing services, such as:

Monitoring/improving gas exchange
Monitoring/enhancing airway clearance
Pain relief
Monitoring for clinical complications such as:
- Shortness of breath, shaking, chills, or recurrent/persistent fevers
- Rapid or painful breathing
- Bloody or rust-colored mucus
- Chest pain that worsens with cough or inhalation
- Night sweats or unexplained weight loss
- Monitoring of comorbidities

Once stabilized, the resident returns to a non-skilled level of care, no longer requiring observation and assessment at an increased frequency and intensity. Without the 14-day IV look back, these residents would not be likely to fall into one of the skilled RUG levels and therefore might not be perceived as requiring skilled services.

Grace period

> ➢ ***Recommendation: CMS should retain the grace period provision, which allows needed flexibility and improves the administration of the SNF PPS***

The grace period provision is working well and should not be changed. It allows needed flexibility that permits smoother administration of required evaluation and re-evaluation of varied patients, rather than a one-size-fits-all rigid rule.

Residents who require ultra high or very high rehabilitation can not always get the five days and 500 to 720+ minutes of rehabilitation in the initial five day assessment, without the use of grace days. An example would be of a patient that enters a SNF on a Wednesday. If the facility does not provide rehabilitation on Sundays, the patient would not be able to receive the five days of therapy required to place him or her in a RU or RV RUGs level. In this example, when services are provided, the facility will not be reimbursed for the care it delivered without the grace period.

Proposed Refinements to the Case-Mix Classification System

Unification of the Post-Acute Care Payment Systems

[p. 29081]

> ➢ ***Recommendation:*** ***The Alliance supports Medicare payment 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 patients. However, the Alliance urges CMS to proceed cautiously, engage in relevant research and closely consult with post-acute care stakeholders, including providers and beneficiary groups.***

Currently, the Medicare program pays separate, prospectively-set rates to providers in four different post-acute care settings: Skilled Nursing Facilities (SNFs), Long-Term Acute Care Hospitals (LTACHs), Home Health Agencies (HHAs), and Inpatient Rehabilitation Facilities (IRFs). We observe many distinctions among these provider types. CMS requires different patient assessment instruments for three of the four post-acute care provider categories. The law requires that each provider type be certified under separate criteria. CMS ensures patient safety and quality in each of these settings through vastly different regulatory structures. In addition, the physical settings in which patients receive care greatly differ, ranging from a patient's home to a nursing facility to a hospital.

Most post-acute care providers, physicians, and others involved in patient care believe in a hierarchy of acuity among the different settings and assume that patients with the highest acuity clinical needs will receive care in the highest acuity setting. For example, a recent study of SNF and LTACH clinical data showed that patients with higher severity of illness (SOI) levels (SOI 3 and 4 on a scale of 1-4) received care in LTACHs while patients with lower SOI levels received care in SNF settings.[13] However, some research as well as provider experience shows that different post-acute care settings sometimes serve similar patients. This overlap in patient populations can occur for legitimate non-clinical reasons or clinical reasons that are not measurable by research. CMS should recognize that a certain amount of overlap is inevitable and necessary to ensure continuity of patient care across settings.

However, the overlap is sometimes inappropriate and results in Medicare overpayment, problematic clinical treatment, or both. CMS, Congress and MedPAC are understandably concerned about the ambiguity of patient placement within the current post-acute care system. As a result, all have recently discussed the study and eventual design of a unified Medicare post-acute care payment system. At the March 2005 MedPAC meeting, members inquired about the study of a unified post-acute care payment system and, on

[13] **http://www.healthstrategies.net/abot/archive/March 2004 Fact Sheet.pdf.**

June 16, 2005, the U.S. House of Representatives Committee on Ways and Means held a hearing on this topic. In theory, under a unified payment system, Medicare would pay all post-acute providers the same rate which would be determined by a variety of clinical factors such as patient diagnosis, severity of illness, and resources necessary to treat patients.

As CMS begins to think about the parameters of a unified payment system, we strongly recommend the following:

- ***Assessment Tool.*** The agency must develop a robust, reliable and comprehensive common patient assessment tool. The development of such a tool is a very complicated and important task. The range, depth, and content of clinical information necessary to evaluate and treat LTACH patients are more comprehensive than are currently captured in existing post-acute care assessment instruments. CMS should ensure active participation by clinicians most familiar with each post-acute care setting. Such participation will raise awareness about the range of clinical information necessary to assess patients across the full array of post-acute care providers.

  The assessment tool should capture important social factors that affect the type of setting most appropriate for the individual. For example, a SNF may be more appropriate than home health for the sole reason that family support is inadequate to maintain a person at home. Given recent research that shows the significant stress (anxiety and depression) related to institutionalization of a significant other,[14] the role of and proximity to family are important considerations in the placement assessment process.

  As important as family considerations are consumer preferences, which an assessment focused exclusively on clinical needs would miss. Even in a market where all types of post-acute care providers are available, a consumer may have a strong preference for a particular provider because of social, financial, or other reasons.

- ***Report to Congress.*** CMS should complete the report to Congress due January 1, 2005, on the development of instruments to assess the health and functional status of beneficiaries using post-acute care and other specified services. CMS is required to make recommendations on the use of patient assessment instruments for payment purposes.[15] The assessment instrument required by BIPA is to have readily comparable, statistically compatible, common data elements. The

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[14] **Long-term Care Placement of Dementia Patients and Caregiver Health and Well-being, *Journal of the American Medical Association*, August 25, 2004, Vol. 292, pgs. 961-967.**

[15] **See §545, "Development of patient assessment instruments," of the Medicare, Medicaid, and SCHIP Benefits Protection Act of 2000 ["BIPA"], Pub.L. No. 106-554 (Dec. 15, 2000).**

standard instruments developed are to supersede the assessment tools now required.

- ***Preserving a Role for Clinical Judgment*** – We agree with the premise that post-acute placement decisions should rely heavily on patient clinical characteristics and needs (as well as social factors mentioned above). Patients who can be safely and effectively cared for in SNFs should not be treated in LTACHS or IRFs. Conversely, severely ill, medically complex patients needing a hospital-level of care should have access to the intensive interventions available in LTACHs. However, from a clinical perspective, determinations about appropriate placement are not always clear. In cases where the issues are complex, input from treating physicians is critical. Any system should allow for flexibility so that clinical judgment can be effectively exercised in the best interests of patients.

- ***Facility Capacity.*** CMS should also focus on ensuring that post-acute care providers have the capacity to meet the needs of the patients. Staffing levels, staff skill mix, availability of diagnostic tests, sophistication of technology and intensity of services vary tremendously across settings. If the goal of a new system is to match patients with post-acute care settings better, it needs to ensure that the capacity of each provider type is, in fact, a good match for the patients actually admitted in each of the settings. The provider survey and certification process should ensure that the each post-acute care provider has the infrastructure to provide care that best meets each consumer's assessed needs and, as possible, preferences.

- ***Accounting for Differences in Market Capacity*** – Adjustments to the post-acute care payment system must not assume that all Medicare beneficiaries have equal access to all types of post-acute care. Even though a beneficiary's clinical profile is a good match for home health care, a home health agency may not be available or may not have capacity to take a new patient. Therefore, the system must be flexible enough to allow for limitations in post-acute care supply.

- ***Input and Support.*** In making adjustments to the post-acute care payment system, CMS will need support and technical expertise from a wide array of post-acute care stakeholders, including nursing home providers. **With a national membership base and in-house expertise, the Alliance and its members should be a key CMS partner in the development of the unified post-acute care prospective payment system (PPS).**

As we stated above, CMS should work toward ensuring that the financial incentives in the Medicare payment system result in the best clinical post-acute placement for patients. We understand that CMS is considering a unified post-acute care payment system to achieve this goal. However, we strongly encourage CMS to consider and assess the widest range of policy options available for achieving this goal. There are many potential changes CMS could make within the existing system that would better align financial incentives with clinical placement decisions. These include ideas such as

tightening and enforcing new and existing certification criteria for IRFs and LTACHs, and enhancing the role of the QIOs in reviewing appropriateness of patient placement. In addition, we support the use of hospital discharge planning as a starting point to standardize post-acute assessment tools. For patients with prior hospital stays, CMS should continue to apply hospital discharge planning that is already required by law and regulations. (See §§1861(e)(6)(B) and 1861(ee) of the Social Security Act, and regulations at 42 CFR §482.43.)

Proposed Refinements to the Case-Mix Classification System

Pay for Performance

[p. 29080 – 29081]

The Alliance appreciates the continued efforts by CMS to improve quality of care and welcomes the opportunity to comment on the policies mentioned in the Proposed Rule.

In the Proposed Rule, CMS acknowledges that nursing homes have undertaken numerous efforts to promote quality of care, and discusses its own thinking on quality of care initiatives. The Alliance has worked hand-in-hand with CMS on the Nursing Home Quality Initiative and the Long Term Care Task Force. The Alliance is a leader in the nursing home community in the development of quality indicators that are now mandated to be reported to state and federal agencies and to be publicly available. The Alliance supports the dissemination of information to both consumers and payers and believes setting and meeting quality benchmarks are vital activities to achieve the highest level of care. The Department's recent announcement highlighting marked gains in the reduction of chronic pain and the use of physical restraints within two years after launching the Nursing Home Quality Initiative is validation that measurement and disclosure can positively affect patient outcomes.

CMS notes that services for beneficiaries are reimbursed by multiple payers including Medicare Parts A and B, Medicaid, and private insurance. While nursing home revenue comes from a variety of sources, providers do not rely evenly on each of these payment streams. Nursing homes routinely lose money on providing care to Medicaid residents and must rely on Medicare to stabilize their operations. While Medicaid residents account for nearly two thirds of the average nursing home's daily census, Medicaid provides only half of a home's revenue. Medicare, on the other hand, accounts for only 15 percent of an average nursing home's daily census but provides enough payment to be able to balance out the Medicaid losses. The Alliance urges CMS to ensure that pay-for-performance programs in nursing homes do not disrupt the delicate balance of payments. The unfortunate reality is that even small changes in reimbursement in one payment source will likely have a much larger impact on a nursing home's overall revenue stream.

The Alliance endorses the concept of linking Medicare reimbursements to attainment of measurable quality indicators. CMS has already proven in the Premier Hospital Quality Incentive Demonstration that the use of financial incentives can be effective in encouraging facilities to provide high quality care. Certain Members of Congress have applied this model to nursing home providers. On March 17, 2005, Reps. Phil English

(R-PA) and John Tanner (D-TN) introduced *The Medicare Nursing Facility Pay-for-Performance Act of 2005,* H.R. 1381, which outlines one such approach. A companion bill was introduced by Sens. Ron Wyden (D-OR) and Gordon Smith (R-OR) on April 5, 2005, the *Long Term Care Quality Improvement Act of 2005.* The Alliance urges CMS to use these bills as an outline for a nursing facility pay-for-performance program:

- *Measurable Indicators with Providers' Input* – CMS would work with nursing facility providers and independent experts such as the National Quality Forum to develop up to 15 quality measures that nursing facilities would track. These outcome or process measures would include a measure of the level of facility staffing and the mix of licensed staff at a facility. The measures would be risk-adjusted as applied to individual skilled nursing facilities and would take into account the special circumstances of low-utilization facilities. Performance results would be publicly available.

- *Differential Payments* – The payment incentive to achieve the highest possible outcome on each of these measures would be a portion of the Resource Utilization Group (RUG) payments. CMS would use a current services budget baseline, such that the level of expenditures for nursing facilities would continue the RUGs payments from Fiscal Year 2005.

  Over a two year period, a reimbursement incentive mechanism would be implemented that would give a one percent RUG add-on above the market basket increase to nursing home facilities that perform in the top ten percent in quality performance measures in the first year. In the second year, facilities performing in the top 20 percent would receive a one percent add-on, with those in the top ten percent receiving a total of a two percent add-on. After two years, facilities performing at the bottom percentiles, determined against a baseline established in year one, would receive a one percent cut in total payments.

  This methodology would require continual improvement from year to year. Financial incentives go to those who perform at the highest level each year. While rewarding quality, the program would penalize static behavior. Those facilities that do not make quality improvements are those that receive a payment reduction.

- *Budget Neutrality* – This approach envisions no net gain in aggregate spending on nursing facilities. The Secretary would be directed to assume the current baseline, including a full market basket increase and no payment changes to the existing RUGs. Overall spending on nursing facility services would track that baseline. Payment increases to high quality nursing homes would be balanced out by payment decreases to those facilities that do not show improvement over the initial quality measurement period.

The Proposed Rule appropriately acknowledges that quality measures must be broad-based and designed to affect change across the mix of residents in a facility, not just a

part of a nursing home. The Alliance agrees with CMS and believes that pay-for-performance programs should enhance nursing homes' overall goal of providing quality care across the nursing home setting. A variety of measures should be used to target quality outcomes across the facility. For example, for residents who require skilled care, quality indicators must reflect this population's primary goals of rehabilitation and home discharge. For other residents, measurements may need to reflect other goals such as maintenance of function and overall health. In order to make meaningful comparisons of the results, measurements would need to be risk-adjusted.

While the Alliance fully supports measuring quality within the nursing home setting, we urge CMS to consider additional ways to measure quality outcomes in the nursing home population. Poor quality of care has a much broader impact on the health care system than the location in which the poor care is delivered. For example, poor infection control could lead to a resident contracting pneumonia, thus requiring hospitalization. Hospitalizations are not only traumatic for residents and their families but cost thousands of dollars. Improved care benefits residents and reduces costs to Medicare, Medicaid and other payers. Quite simply, if residents are appropriately receiving care in a skilled nursing facility instead of a hospital, both the resident and the taxpayer are the ultimate winners.

The Alliance believes unplanned hospitalization is an area worthy of further CMS analysis. Hospitalization rates are measurable and easily obtainable from current data already submitted to the agency. An analysis could be made of current rates of unplanned hospitalization and a baseline measure established. A calculation could be made of the costs to the Medicare program of unplanned hospitalization. We would expect the cost for all unplanned hospitalizations in a year to run in the millions of dollars. Reducing unplanned hospitalizations would provide significant savings to the entire Medicare program.

CMS should consider creating a demonstration project or a pilot program to study nursing facilities and unplanned hospitalization rates. Medicare could provide financial rewards to nursing facilities that attain a certain target level or show improvement. CMS would need to work with stakeholders to determine how much progress is reasonable to expect from the initial measurement period. The goal of any demonstration would be to develop quality measures that move beyond the setting where the care is provided to acknowledge how quality impacts the health care system as a whole. The Alliance looks forward to working with CMS along these lines.

In sum, CMS, in collaboration with nursing facility providers, has made great strides in the quality area. The Alliance requests that CMS continue these efforts by partnering with nursing homes to develop pay-for-performance measures similar to those proposed in the *Medicare Nursing Facility Pay for Performance Act*, or other programs that provide meaningful incentives for nursing homes to continue to improve quality of care.

Additional Issues:

Concurrent Therapy
[p. 29082 – 29083]

> ***Recommendation: CMS should proceed cautiously in adopting new policies on "concurrent therapy;" it should consult the SNF and rehabilitation industries before it does so; and it should engage in notice-and-comment rulemaking before it cuts back on currently covered therapy services.***

CMS has invited comment on the most effective way to prevent the abuse of concurrent therapy, and to ensure that it is performed only in those instances where it is clinically justified. [p. 29083, 2d column.] CMS has acknowledged that concurrent therapy can have a legitimate place in the spectrum of care options available to therapists treating Medicare beneficiaries, as long as its use is driven by valid clinical considerations. [p. 29083, 1st column.]

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

The Alliance believes that the development and issuance of new policies affecting concurrent therapy, especially policies that would cut back on existing approved coverage policies for Medicare payment, should not be based on imprecise and indistinct generalized discussions in preambles and manuals. Rather, precise definitions and payment rules should be proposed in the Federal Register for public comment before being adopted and put into effect. CMS should conform in this respect to the rulemaking provisions of the Medicare statute,[16] specifically:

> No rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities or organizations to furnish or receive services

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[16] **Section 1871(a)(2) and (b)(1) of the Social Security Act**

> or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation....
>
> . . . before issuing in final form any regulation . . ., the Secretary shall provide for public notice of the proposed regulation in the Federal Register and a period of not less than 60 days of public comment thereon.

The Alliance believes that CMS' apparent approach of "regulating by preamble" would be in conflict with the rulemaking provisions of the Social Security Act and the Administrative Procedure Act and with the obligations of notice and comment rulemaking. The preamble can only lead to further confusion and disarray in a service line that has experienced greater and more frequent changes in reimbursement and coverage than any other.

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

> The practice of one professional therapist treating more than one Medicare beneficiary at a time -- in some cases, many more than one individual at a time.[17]

The problem with this ambiguous language is that it covers both the "permitted" and the "prohibited." Practitioners and providers can envision a scenario where professional supervision is so lax as to fail to meet regulatory minimums. However, under the preamble's definition, there is no inherent inconsistency between what CMS has termed "concurrent therapy" and skilled therapy. By CMS' own reckoning, the expression "concurrent therapy" would include the "overlap in the time of concluding treatment to one individual and the time of commencing the treatment of another, even to the point of briefly providing therapy concurrently in certain cases," a practice that the preamble acknowledges is allowed.[18] With the use of such contradictory language, CMS could not reasonably expect providers and practitioners to understand what Medicare prohibits, and what it permits.

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

> . . . reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.[19]

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17 **66 Federal Register 23991-92.**

18 **Id.**

19 **§1862(a)(1)(A) of the Social Security Act, 42 U.S.C. §1395y(a)(1)(A).**

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

The current state of the CMS Manual instructions only serve to confuse matters further. CMS' policies had been published in the Skilled Nursing Facility Manual. That Manual has been superseded by the Medicare Benefit Policy Manual but the applicable instructions have been miscodified.[20]

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

> Reasonable and Necessary. --To be considered reasonable and necessary the following conditions must be met:
>
> The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition,
>
> The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision . . . .
>
> There must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the patient's restoration potential after any needed consultation with the qualified physical therapist or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state, and

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[20] **For example, interpretative guidelines formerly contained in §230.3 of the SNF Manual now appear in the Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 15, "Medical and Other Health Services," §220, "Coverage of Outpatient Rehabilitation Therapy Services," §220.2, "Reasonable and Necessary Outpatient Rehabilitation Therapy Services," §220.2.B., "Reasonable and Necessary." See Rev. 34, issued 05-06-05, effective: 06-06-05, implementation: 06-06-05. However, these new provisions implement the outpatient therapy benefit under Part B. The Part A benefit provisions in this Manual are referred to in Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §50, "Covered Extended Care Services," §50.3, "Physical, Speech, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements With the Facility and Under Its Supervision." Note, however, that the language of the SNF Manual is not in fact incorporated here. Note further that the incorporations by reference in §50.3 to Chapter 1 of the Medicare Benefits Policy Manual, "Inpatient Hospital Services," are incorrect; they refer instead to various matters relating to pregnancy.**

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

It is not clear to us how a concurrent therapy limitation on the coverage of therapy services can be adopted without doing violence to CMS' long standing definition of covered therapy services. Any approach to limiting current Medicare payments for covered therapy services when they constitute "concurrent therapy" must be clearly defined, easy to administer, and adopted only after notice and comment rulemaking procedures.

Qualifying Three-Day Inpatient Hospital Stay Requirement
[§VI, pp. 29098 – 29100]

> ***Recommendation: CMS should include hospital "observation days" when calculating the 3-day inpatient hospital stay requirement for SNF admission***

CMS has invited comments on the possibility of counting the time spent in hospital observation status toward meeting the SNF benefit's qualifying 3-day hospital stay requirement, when the observation status is immediately prior to a hospital inpatient stay.

To qualify for a Medicare Part A stay in a skilled nursing facility, a beneficiary must first be an inpatient in a hospital for three or more consecutive days, before being admitted to a SNF to receive daily skilled services. The three day hospital stay requirement dates back to 1965 when Medicare legislation was first initiated, and before observation days became prevalent in hospitals. The hospital stay preceding a SNF stay was intended to ensure the Part A beneficiary in a SNF was in need of skilled care, not custodial care.

A distinction has been made between observation services and emergency room services in section VI on page 29099: "(Medicare Benefit Policy Manual), Chapter 6 (Hospital Services Covered Under Part B), section 70.4 (Outpatient Observation Services) in which a patient who needs more care than can be provided in an emergency room is moved from the emergency room, placed in a hospital bed in the appropriate hospital unit and monitored by the unit nursing and physician staff." Although a patient in an observation status is considered an outpatient for hospital billing purposes, by the definition above the observation patients are in need of a greater level of care than patients remaining in the emergency room.

The hospital observation period, prior to an inpatient admission, should be combined with the hospital inpatient stay, to meet the 3-day hospital stay requirement necessary to qualify a beneficiary for Medicare Part A services in a skilled nursing facility. Hospitals are acute care settings. Patients are being observed while in an observation status, as well as after they are formally admitted as an inpatient. If it is determined a patient needs to be admitted after an observation period, the patient is in need of professional care, not being prepared for a custodial setting.

In addition to the three day qualifying hospital stay, a Medicare beneficiary must have a physician certify the need for daily skilled care, for a beneficiary to receive Part A coverage in a skilled nursing facility. When the daily skilled services end, the Medicare Part A coverage also ends. Medicare Part A is not responsible for custodial care in a skilled nursing facility.

> ➢ ***Recommendation: CMS should re-evaluate its policies implementing the 3-day hospital stay requirement to facilitate beneficiary eligibility for SNF care***

CMS should enable SNFs to rely on a hospital attestation that the 3-day stay requirement has been met. If the attestation later turns out to be incorrect, the beneficiary and the SNF should be held to be without fault and bear no financial responsibility for the Part A SNF stay.

CMS should include all time spent by a beneficiary in an acute care hospital in the calculation of the 3-day stay requirement.

CMS should exercise the discretion of the Secretary to eliminate the requirement of qualifying 3-day stay requirement; and

CMS should, at a minimum, initiate a demonstration to evaluate the implications of selectively eliminating the three-day inpatient hospital stay requirement.

Consolidated Billing

Exclusions
[pp. 29097 – 29098]

> ***Recommendation: All drugs used by oncologists in cancer treatment, including anti-emetics and anti-neoplastics, should be excluded from the SNF consolidated billing requirements***

CMS invited public comments to identify, in any of the four excluded service categories, codes representing recent medical advances that might meet the criteria for exclusion from SNF consolidated billing. Those criteria were described as high cost, low probability events that could have devastating financial impacts because their costs far exceed the payment SNFs receive under the PPS. Under §1888(e)(2)(A)(iii) of the Social Security Act, the Secretary is authorized to designate additional, individual services for exclusion within each of the specified service categories.

The Alliance believes that CMS should implement this authority generously and consistently with its intent, namely, wherever possible to avoid allowing anomalous and relatively rare expensive service costs from distorting the SNF PPS. Although we are not listing codes of particular discrete items or services, we are confident that CMS is aware of the codes that qualify for exclusion under the applicable criteria and that therefore

ought to be excluded. We expect that others commenting on this proposed rule will probably make specific recommendations.

In particular, drugs in the four excluded categories that are paid for separately when administered in hospital outpatient departments, in order to achieve fairness and avoid distortion of the hospital outpatient PPS, should be identified as also qualifying for exclusion from SNF consolidated billing, since they obviously meet the SNF exclusion criteria. Drugs "unbundled" in the hospital outpatient setting should also be "unbundled" for SNFs, to achieve the fairness and efficiency intended by Congress.

In addition, many currently non-excluded drugs that are used in the treatment of cancer should also be excluded from SNF consolidated billing. Such drugs are commonly used by oncologists and are standard components of cancer treatment. These include anti-emetics, anti-neoplastics, and supportive care drugs. Cancer patients utilize SNF resources very expensively, and can easily become cost outliers that distort the SNF PPS. Including these additional types of drugs would further rationalize consolidated billing and the SNF PPS. SNFs would no longer have to go without adequate payment for this important and expensive category of service, and access of Medicare cancer patients to SNF services should be enhanced.

The Alliance would again like to take this time to thank CMS for the opportunity to comment on the NPRM.

Stephen L. Guillard
Chairman
The Alliance for Quality Nursing Home Care

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20-H

July 11, 2005

Mark B. McClellan, M.D.
Administrator
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445-G Hubert H. Humphrey Building
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Washington, DC 20201

Re: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2006/File Code CMS 1282 (70 FR 29070)

Submitted electronically and by hand

Dear Administrator McClellan:

On behalf of the American Physical Therapy Association (APTA), we appreciate the opportunity to comment on provisions of the 2006 Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Proposed Rule. The APTA is a professional organization representing the interests of 67,000 physical therapists, physical therapist assistants, and students of physical therapy. Physical therapists play an essential role in providing rehabilitation services to patients in skilled nursing facilities (SNFs). APTA therefore has a strong interest in many of the provisions in this proposed rule.

New Case-Mix Refinements (pg. 29078)

APTA commends CMS for the development of nine new Resource Utilization Groups (RUGs) that take into account those patients who require both extensive nursing services and extensive rehabilitative services. We believe these new categories more accurately reflect the resources required to treat many of the patients currently receiving care in SNFs. CMS should monitor and evaluate patients' access to care and the quality of care they receive under this new refined system. It is important to ensure that facilities do not have incentives to avoid certain types of patients based on the new RUGs groups.

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February 1-5
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PT 2006:
The Annual Conference
& Exposition of the
American Physical Therapy
Association
June 21-24
Orlando, Florida

Concurrent Therapy (pg. 29082)
In Section 2(B)(7) of the proposed rule, CMS invites public comment on the most effective way to prevent potential abuse of concurrent therapy in skilled nursing facilities, specifically in instances where facility management may try to inappropriately increase productivity by coercing therapists to provide treatment that is not consistent with their professional judgment. APTA agrees with CMS that it would be inappropriate for a facility to pressure physical therapists to increase productivity by providing concurrent therapy. The decision to provide concurrent therapy should be based on the needs of the patient and not influenced by financial incentives or pressures to increase productivity. We believe that there are circumstances when concurrent therapy is appropriate and that physical therapists should use their professional judgment to make that determination. Physical therapists are governed by their state practice acts and by rigorous professional standards of conduct and professional ethics which prevent them from treating too many patients at one time.

APTA 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) and expanded medical review in this area 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, physical therapists working in SNFs should be informed of mechanisms for reporting abusive practices.

APTA suggests that CMS work with the professional organizations to assist with provider outreach and to develop guidance regarding the appropriate use of concurrent therapy. CMS has established coverage guidelines for skilled physical therapy services in its Medicare Benefit Policy Manual, Chapter 8, section 30.4.1, which state that services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a qualified physical therapist;

- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;

- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;

• The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and

• The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

These conditions of coverage can be met during the provision of concurrent therapy. While not every patient would be an appropriate candidate, the ability to provide skilled services to more than one patient, in certain circumstances, is appropriate. Concurrent therapy can provide additional motivation and support to the patients involved. APTA could assist CMS to establish more specific clinical scenarios where the provision of concurrent therapy would be appropriate and those where it would be inappropriate.

Proposed Elimination of Grace Days (pg. 29080)

In the proposed rule CMS states that it has received recommendations to decrease or eliminate the grace day period for the 5-day PPS MDS assessment and is inviting public comment on this proposal. APTA believes that the elimination of the grace day period has the potential to harm beneficiaries and would place additional pressure on facilities which are already experiencing difficultly with adequate staffing. Sometimes a patient who is discharged from an acute care hospital and admitted to a SNF is not able to receive therapy on the day of admission due to health or other reasons. Also, physicians tend to discharge the patient from the hospital to the SNF on weekends when physical therapists may not be at the facility. This becomes a larger problem in rural areas, where physical therapists may not be available to furnish services at the facility 7 days per week. Therefore, the SNFs need some flexibility with respect to the 5 day assessment.

In addition, CMS explains the rationale for the appropriate use of grace days in the preamble of the 1999 SNF PPS Final Rule. Although CMS encourages facilities to conduct timely assessments, there was recognition that 5 days may prove to be too short a time period for patients who are extremely frail and need a few extra days to stabilize before beginning rehabilitation: "The grace days are also provided to offset any incentive that facilities may have to initiate therapy services before the beneficiary is able to tolerate that level of activity."[1] Many patients who are admitted into SNFs from the acute care setting are indeed too frail to begin therapy. CMS goes on to state that:

> We also intended to minimize the incentive to facilities to provide too high a level of rehabilitation therapy to newly admitted beneficiaries. Having these extra few days allows time for those beneficiaries who need it to stabilize from the acute care setting and be prepared for

[1] 64 FR 41657

> the beginning of rehabilitation in the SNF. We expect facilities will not compromise any beneficiary's health by beginning rehabilitation therapy prematurely or at a level that is too rigorous for the individual's status. In summary, use of grace days is acceptable and permitted for patients with any condition." [2]

CMS reiterates in the final rule that routine use of grace days could trigger an audit, and discourages the practice. APTA feels that the use of grace days, in many cases, allows facilities to provide better care to their patients. Because facilities cannot control the number of patients who would be better served by the use of grace days, we believe that their use should not put facilities at higher risk of an audit.

Proposed Elimination of Projected Therapy Minutes (pg. 29080)
In the proposed rule, CMS solicits public comments regarding the elimination of projected therapy minutes. The elimination of projected therapy minutes also has the potential to severely impact quality of care. A therapist's professional judgment allows them to predict with great accuracy how much therapy a particular patient may need, prior to the time a patient may be ready to begin the total amount of therapy. The use of projected therapy minutes allows patients to adjust to the SNF rather than being aggressively treated upon admission. It is important to allow a facility to project therapy minutes to accurately reflect the resources and associated costs incurred in treating a patient.

Observation Status (pg. 29099)
APTA strongly supports counting the time a patient spends in observation status toward the required 3 day hospital stay for a Medicare covered SNF stay. Patients are treated identically whether they are under observation or have been formally admitted to the hospital. Not counting this time toward the 3 day requirement only drives up costs for Medicare if the physician then decides to formally admit a patient for at least three days in order to qualify them for a Medicare covered stay in a SNF.

"Look Back" Provision (pg. 29080)
APTA believes that using the MDS data reflecting only those services that are actually furnished during a SNF stay could detract from appropriate patient care. Quite often, frail elderly patients have several comorbidities and have received extensive medical interventions prior to admission in a SNF. These factors, therefore, can be very good indicators of patients who require skilled observation upon admission to a SNF to ensure that their medical status remains stable. If these factors are not adequately taken into account, it could result in increased readmissions back to the acute care setting and ultimately higher costs to the Medicare program. By taking into account patients' prior medical status, staff is able to more adequately assess the resource needs of medically complex patients and ease their transition into the SNF.

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[2] Id.

Elimination of the "look back" provision will not ensure more accurate patient classification, but instead, will put certain patients at risk of receiving inadequate care during their SNF stay.

Conclusion

APTA appreciates the opportunity to comment on this proposed rule. While APTA commends CMS for the development of nine new RUGs that more accurately address the types of patients being seen in SNFs, we request serious consideration of our comments on other provisions of the proposed rule. With the increased focus on patient satisfaction and quality measurement in the SNF setting, it is more important then ever before to provide care that is appropriate to the unique needs of each patient. Please do not hesitate to contact Karen Stavenjord at karenstavenjord@apta.org or 703/706-8508 with any questions you may have.

Respectfully submitted,

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Vice President, Government Affairs

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JUL 12 2005

July 12, 2005

Centers for Medicare & Medicaid Services
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Washington, DC 20201

Re: CMS-1282-P

Dear Colleagues:

I am submitting the following comments on Medicare reimbursement rules for skilled nursing facilities on behalf of the Center for Medicare Advocacy, Inc.

Attorneys from the Center for Medicare Advocacy, Inc. represent the plaintiffs in *Landers v. Leavitt*, No. 3:04CV1988 (JCH) (D.Conn.). This case challenges the Centers for Medicare & Medicaid Services' policy of denying observation days and emergency room days when calculating Medicare's three-day prior hospital stay requirement, a prerequisite to Medicare coverage of care in a skilled nursing facility. I was a member of the Technical Advisory Panel for the Urban Institute's study on refinements to the Medicare PPS system.

New RUGs categories

Both the GAO and MedPAC have expressed concern with whether the RUGs-III system adequately reflects the costs of services for beneficiaries who have significant needs for both extensive services and rehabilitation services. The proposed creation of nine new RUGs categories is intended to respond to this concern.

While the Center supports refinements to the reimbursement system to reflect costs of care more accurately, we want to assure that reimbursement policies not encourage poor care outcomes for beneficiaries. Paying more when certain services are provided means that those services will be

provided. Susan L. Mitchell, "Tube-Feeding Versus Hand-Feeding Nursing Home Residents with Advanced Dementia: A Cost Comparison," *Journal of the American Medical Directors Association* S23-S29 (March/April 2004 Supplement) (suggesting financial incentive – i.e., higher Medicaid reimbursement rates – to use tube feeding, rather than hand-feeding, for residents with dementia).

We also oppose basing SNF reimbursement rates on services that were provided only in the acute care hospital. *See* discussion below (point 1). To the extent that the new RUGs categories are based on services provided in the hospital (e.g., IV feeding in the last seven days; or IV medications, ventilator/respirator. tracheotomy, or suctioning in the last 14 days), we believe they are inappropriate determiners of SNF levels of payment. If Medicare beneficiaries who receive certain services in the hospital need additional skilled nursing care and observation services, those nursing needs should be identified and should form the basis of the Medicare SNF payment.

Since CMS explicitly requests public comment on whether it should continue to use the 14-day look-behind provision, it should not base its new RUGs categories on care provided during the look-behind period.

Finally, we believe there is clearly a need for better coordination of reimbursement and standards of care. Reimbursement policy should support the care that is required by the Nursing Home Reform Law (1987), not contradict it or create competing incentives.

Policy options on which CMS invited public comment

1. 14-day "look-back" provision, 96 Fed. Reg., at 29,079-29,080

CMS asks whether classifications for purposes of Medicare SNF reimbursement should reflect "only those services that are actually furnished during the SNF stay itself rather than during the preadmission period." 96 Fed. Reg., at 29,079. Our answer is yes. There is no rationale for basing SNF payments on services that were provided solely in the acute care hospital. As stated above, we believe that Medicare reimbursement for SNF care should reflect care and services provided to beneficiaries while they are in the SNF. If Medicare beneficiaries who receive certain services in the hospital need additional skilled nursing care and observation services, those nursing needs should be identified and should form the basis of the Medicare SNF payment.

2. Nursing home quality

CMS suggests that nursing home quality has improved as a result of the Nursing Home Quality Initiative and its work with the SNF industry on the development of "valid quality measures." 96 Fed. Reg. 29,080.

The only evidence of facility improvement is facilities' self-reported, unaudited resident assessment (MDS) data. There is independent evidence that outcomes for residents have **not** improved as a result of the Nursing Home Quality Initiative. Robert L. Abel, et al., "Quality Improvement in Nursing Homes in Texas: Results from a Pressure Ulcer Prevention Project," *Journal of the American Medical Directors Association*, Vol. 6, No. 3, page 181, 186 (May/Jun. 2005) (finding "no

significant difference between pressure ulcer incidence rates at baseline and at remeasurement" following Texas nursing facilities' work with Quality Improvement Organization).

Moreover, the validity of the quality measures used in the Nursing Home Quality Initiative is in question. Anna Rahman, "Debate Looms on CMS Use of Pain Measure in Nursing Homes," *Aging Today*, Vol. XXVI, No. 2 (Mar.-Apr. 2005), http://www.asaging.org/at/at-262/Forum_Debate_Looms_On_CMS.cfm (questioning the validity of reports that the prevalence of pain declined as a result of the Nursing Home Quality Initiative).

3. Pay-for-performance, identified as another way of providing support to improve quality of care, 96 Fed. Reg. 29,080-29,081, is also questionable.

Although there is no consensus about what pay-for-performance might mean (and CMS, at a recent meeting, described one possibility as sharing with SNFs the cost savings that Medicare would enjoy from reduced hospitalizations or reduced use of emergency rooms by SNF residents), the general idea seems to be paying some facilities more money for providing better care. Usually, pay-for-performance is described as budget-neutral (i.e., keeping total nursing home reimbursement constant but redistributing the amounts paid to facilities, based on the quality of their performance and their residents' outcomes).

One concern is that a budget-neutral pay-for-performance program may take money from poorer facilities and redistribute it to wealthier facilities. In light of studies suggesting that some poorly-performing facilities serve poor people and members of minority groups, *see* Vincent Mor, et al, "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care," *The Milbank Quarterly*, Vol. 82, No. 2 (Jun. 2004), http://www.milbank.org/quarterly/8202feat.html, such a project could be a reverse Robin Hood – taking from the poor to pay for the rich.

Pay-for-performance also may create incentives for SNFs to avoid residents with difficult health care needs. If people with significant care needs are denied admission to SNFs, they will likely remain in hospitals for longer periods of time awaiting nursing home placement, nullifying cost savings. The Office of Inspector General's early reports on the RUGs-III reimbursement system found that various beneficiaries became more difficult to place in skilled nursing facilities following implementation of the system. Office of Inspector General, HHS, *Medicare Beneficiary Access to Skilled Nursing Facilities*, OEI-02-01-00160 (Jul. 2001), http://oig.hhs.gov/oei/reports/oei-02-01-00160.pdf (reporting difficulty in placing beneficiaries needing IV antibiotics/expensive drugs; ventilators; ESRD/dialysis; or having behavior problems/Alzheimers; wound care/decubitus ulcers; and infection disease/isolation needs; and some difficulty placing patients with tracheotomies or respiratory failure; patients requiring parenteral or enteral feedings; mental health issues; chemotherapy needs; HIV/AIDS). Since providers will also respond to the financial incentives in pay-for-performance programs, it is necessary to assure that the incentives not prevent or delay the admission of beneficiaries who need and choose SNF services and that they be aligned with the care standards mandated by the Nursing Home Reform Law.

In addition to these concerns, we also question which measures would be used to evaluate facilities.

Using quality measures alone would be insufficient to give a comprehensive view of nursing home performance. Survey and staffing data are also relevant and need to be included. Appended to these comments, and incorporated by reference, is a memorandum that I gave to CMS' Long-Term Care Task Force in May 2005. The memorandum looked at quality measures, survey results, and staffing ratios in selected nursing homes that were in the news because of the extremely poor care they provided. The point of the memorandum was to demonstrate that some facilities with "good" quality measures provide very poor care to residents, as determined by survey deficiencies and public enforcement activity. Pain, in particular, seemed to be a measure where poor facilities report good results.

4. Site-neutral payment

Another possible payment innovation discussed in the proposed rules is "developing payment policy that is as neutral as possible regarding provider and patient decisions about the use of particular post-acute services" – that is, using site-neutral payment for post-acute providers. 96 Fed. Reg., at 29,081.

This proposal is also of concern to the Center. While it appears to make little sense to pay vastly different amounts for the same services, based solely on the setting of care, similar cost-containment efforts in the past have had unintended negative consequences. Costs shifted from one setting to another; uniform rates gave windfalls to some providers, eliminated other providers, and did not improve care for beneficiaries; and beneficiaries and providers lost the federally-guaranteed opportunity to make choices about the site of health care. Appended to these comments, and incorporated by reference, is testimony that I gave on these issues to the House Ways and Means Committee's Subcommittee on Health on June 16, 2005 (Hearing on Post-Acute Care).

5. Qualifying Three-Day Inpatient Hospital Stay Requirement, 96 Fed. Reg., 29,098-29,100.

As disclosed above, attorneys from the Center for Medicare Advocacy represent plaintiffs in *Landers v. Leavitt*, which challenges CMS' interpretation of the three-day qualifying hospital stay rule. We will confine our comments here to policy arguments.

The Center believes that 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 formal in-patient status, CMS should 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.

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 Medicare reimbursement to the acute care hospital, if the beneficiary is later formally admitted as an in-patient, all components of a beneficiary's hospital stay are treated as a single in-patient episode and a single payment is made to the hospital by the Medicare program. CMS, *Medicare Hospital Manual* §400D. 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 the course of 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.

The Center has successfully challenged denials of Medicare coverage for a SNF stay based on the alleged failure of the beneficiary to meet the three-day prior hospitalization requirement. The federal district court in Connecticut rejected the Fiscal Intermediary's denial of SNF coverage for a beneficiary whose three-day in-patient hospital stay began in the emergency room. The court ruled that the "proper focus . . . [is] the continuity of the plaintiff's treatment." *Jenkel v. Shalala*, 845 F. Supp. 69, 70 (D. Conn. 1993). Finding that the beneficiary's in-patient hospital stay began on June 11, 1998, when the beneficiary was taken to the emergency room, the court ruled that "the hospital's later 'formal admission' of the plaintiff was merely a *nunc pro tunc* ratification of her *de facto* admission at the time of her arrival in the emergency room." *Id.*

In the proposed rule, CMS asks whether it should revise its policy for counting days in an acute care hospital solely for beneficiaries on observation status. While the Center supports this change, we also believe that the same policy rationale should lead to a change for emergency room use as well. The distinctions CMS makes between observation status and emergency room stays do not withstand scrutiny.

Contrary to CMS' contention that emergency room stays are not "substitutes for or equivalent to inpatient hospital care," 96 Fed. Reg., at 29,099, *The National Hospital Ambulatory Medicare Care Survey: 2003 Emergency Department Survey*, Advance Data from Vital and Health Statistics, No. 358 (May 26, 2005), http://www.cdc.gov/nchs/data/ad/ad358.pdf, reports that a considerable amount of care is given to patients in the emergency room:

> Diagnostic and screening services were ordered or provided by hospital staff at 89.7 percent of ED visits, ... Frequently mentioned services included medical screening exam (68.5 percent), complete blood count (CBC) (33.0 percent), pulse oximetry (23.4 percent), chest x ray (19.3 percent), other blood tests (19.2 percent), and urinalysis (17.7 percent). Imaging was provided at 42.9 percent of visits. Blood tests and cultures were ordered at 36.2 percent and 9.7 percent of visits, respectively. . . . About 9 percent of ED visits had no diagnostic or screening services.

Report, page 9.

CMS notes that many visits to the emergency rooms do not result in hospitalization. While true (the 2003 survey indicates that 14% of emergency department visits result in a hospital admission), the point is not relevant here. If a patient in the emergency room is not hospitalized, s/he will not be able to meet the three-day qualifying hospital stay requirement for SNF care. But if s/he is hospitalized following her/his emergency room stay, we believe the time spent in the emergency room should be included in Medicare's calculations.

Our position – that all time spent in an acute care hospital should be counted towards meeting the

three-day prior hospital stay requirement – is supported by more than 15 national organizations. Appended to these comments, and incorporated by reference, is a July 3, 2003 letter to Laurence Wilson, CMS, from the Center for Medicare Advocacy, on behalf of these organizations. We sent a similar letter in 2004.

These comments are submitted by the Center for Medicare Advocacy, a private, non-profit organization founded in 1986, that provides education, analytical research, advocacy, and legal assistance to help elders and people with disabilities obtain necessary health care. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training regarding Medicare and healthcare rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.

Sincerely,

Toby S. Edelman

Toby S. Edelman

Appendix 1

QUALITY MEASURES, SURVEY FINDINGS, AND STAFFING FOR SELECTED NURSING HOMES IN THE NEWS (AS REPORTED ON NURSING HOME COMPARE)

Facilities have good performance measures, but bad survey results and low staffing.

1. ARKANSAS ATTORNEY GENERAL'S LAWSUIT AGAINST NURSING FACILITY ALLEGES NEGLIGENT CARE OF ONE RESIDENT AND SUBMISSION OF FALSE CLAIM FOR MEDICAID REIMBURSEMENT;

Alleging that an Arkansas nursing facility and its management companies failed to accurately assess, monitor, and provide care to one (unnamed) resident between July 14 and August 10, 2003, ending when the resident fell from the bed on August 10, 2003 and died four hours later, the Arkansas Attorney General has filed a civil lawsuit charging the facility with neglect, as defined by the Abuse of Adults Act, and with violating the Arkansas False Claims Act. *State of Arkansas v. KMJ Enterprises Fianna Hills, LLC*, Case No. CV05-2703 (Ark. Cir. Ct., Pulaski Co., Mar. 8, 2005). The State seeks civil penalties, restitution, and costs and attorneys' fees.

Nursing Home Compare (visited on April 5, 2005), reports that Fianna Hills had 12 deficiencies at its most recent survey (December 2, 2004), compared with the statewide average of 11 deficiencies. All 12 deficiencies were cited at no-harm levels – 10, at level 2, two, at level one. On the 15 quality measures, Fianna Hills did worse than the statewide average on five:

- Depression or anxiety (13%, compared to Arkansas average of 11%);
- Catheter inserted and left in bladder (9%, compared to Arkansas average of 6%);
- Urinary tract infection (15%, compared to Arkansas average of 8%);
- Weight loss (15%, compared to Arkansas average of 9%); and
- Short-stay residents with pressure sores (27%, compared to Arkansas average of 18%).

Fianna Hills did better than the statewide average on six quality measures:

- Activities of daily living (2%, compared to Arkansas average of 14%);
- Moderate to severe pain (0%, compared with Arkansas average of 5%);
- Physical restraints (11%, compared with Arkansas average of 16%);
- Ability to move about got worse (7%, compared with Arkansas average of 11%);
- Short-stay residents with delirium (0%, compared with Arkansas average of 3%);
- Short-stay residents with moderate to severe pain (0%, compared with Arkansas average of 17%).

Fianna Hills did the same as the statewide average on two measures:

- Loss of control over bowels or bladder (40%); and

- Residents spending most of their time in bed or chair (4%).

Information was not provided on two measures: high-risk residents with pressure sores and low-risk residents with pressure sores.

Fianna Hills reported lower nurse staffing hours per resident per day – 3.51 hours per resident day, compared to the statewide average of 4.0 and the national average of 3.9.

From *Enforcement*, April 2005, #19.

2. ILLINOIS CHARGES NURSING HOME ADMINISTRATOR WITH RECKLESS CONDUCT FOR ALLOWING RESIDENT/CONVICTED SEX OFFENDER TO BE AT PARK NEAR ELEMENTARY SCHOOL

On April 7, the Illinois State Police found eight registered and two unregistered sex offenders living at Emerald Park Nursing Home in Evergreen Park, Illinois. Four days later, another sex offender living at the facility was identified. Calling the facility a "'flophouse,'" Evergreen Park Mayor Jim Sexton described to the Village Board the city's efforts to get the facility's license revoked. "In the meantime, however, trustees have unanimously passed an ordinance that increases local control over the facility in an effort to keep out sex offenders." Janice Neumann, "Evergreen Park nursing home hit. Village says facility houses sex offenders," *Chicago Tribune* (Apr. 20, 2005). The ordinance prohibits facilities from having sex offenders as residents and gives the mayor "some power to suspend or revoke a home's license." The administrator has now been charged with the misdemeanor of reckless conduct for allowing staff to take one of the sex offenders to a park near an elementary school.

A spokesman for the Illinois Department of Health said that the agency began license revocation proceedings last September "and is considering a number of regulatory options." The revocation hearing is scheduled for July 18. Two state senators are demanding that the Department revoke the license immediately.

Nursing Home Compare (visited April 22, 2005) shows that on 13 of the 14 quality measures reported by Emerald Park, the facility performs *better* than the statewide average:

Quality Measure	Emerald Park	Illinois average
Need for help with ADLs increased	4%	13%
Moderate to severe pain	5%	6%
Low-risk residents with pressure sores	0%	3%
Physical restraints	0%	5%
Low-risk residents losing control of bowels or bladder	10%	39%
Catheter	3%	6%
Spending most of time in bed or chair	0%	2%
Ability to move about in room got worse	5%	11%

Urinary tract infection	0%	7%
Too much weight loss	1%	9%
Short-stay residents with delirium	0%	3%
Short-stay residents with moderate pain	0%	22%
Short-stay residents with pressure sores	5%	20%

Emerald Park has worse performance on the quality measure reflecting residents who are depressed or anxious (19%, compared with the Illinois average of 14%). Data on the percentage of high-risk residents who have pressure sores are not available.

Emerald Park's staffing was 2.03 hours per resident day, compared with the statewide average of 3.4 hours per resident day.

The most recent survey data indicate nine deficiencies, including two pattern-level immediate jeopardy deficiencies, cited in February 2004, for (1) failing to protect residents from mistreatment, neglect, and/or theft of personal property and (2) making sure each resident is being watched and has assistance devices when needed, to prevent accidents. Seven deficiencies were cited at the last standard survey in July 2004, none higher than level 2. In the previous survey cycle (Dec. 1, 2002-Nov. 30, 2003, including the standard survey on August 14, 2003), the facility was cited with 11 deficiencies, including four immediate jeopardy deficiencies. An immediate jeopardy deficiency was also cited July 10, 2002.

The *Chicago Tribune* article is available at http://www.chicagotribune.com/news/local/southsouthwest/chi-0504200226apr20,1,3941400.story and from the Center for Medicare Advocacy, on request.

From *Enforcement*, April 2005, #21.

3. NURSING HOME RECEIVING NEW YORK STATE AWARD FOR WORK ON PRESSURE SORES AND FALLS HAS (ACCORDING TO *NURSING HOME COMPARE*) TWO DEFICIENCIES FOR PRESSURE SORES

The Beechwood Continuing Care facility in Getzville, New York received a $200,000 grant from the New York State Department of Health under the State's Patient Safety Initiative, for a project described in the state press release as follows:

> By establishing a *Building on Excellence for Quality* program the facility has experienced documented and sustained improvements in reducing the incidence of falls and pressure ulcers. The four step program along with consistent leadership and more effective utilization of existing resources have contributed to a major change in current practice. As a result, the quality indicators used to identify and respond to falls and skin ulcers among residents have been refined and strengthened.

"State Health Department Announces $1.2 Million in Grant Awards as Part of Statewide Patient Safety Initiative" (Mar. 11, 2005).

Nursing Home Compare (visited March 15, 2005) reports that the facility performs better on 11 of the 13 quality measures for which the facility reported data. (It scored worse on percentage of residents losing control of their bowels or bladder, 59%, compared to the statewide average of 50%, and the same on percentage of residents who lose too much weight, 8%.) These 11 quality measures include two pressure sore measures:

Measure	Beechwood	Statewide average
Percent of high risk residents who have pressure sores	5%	14%
Percent of short-stay residents with pressure sores	16%	23%

Information about the third pressure sore-related measure – percent of low-risk residents who have pressure sores – was one of the two measures for which no data were reported.

However, *Nursing Home Compare* also reports that the five deficiencies, one more than the statewide average of four, include two pressure sore deficiencies among the three quality of care deficiencies, cited in March 2004 and repeated in June 2004:

Deficiency	Date cited	Level of harm	Residents affected
Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores	March 15, 2004	2	Few
Same	June 4, 2004 (corrected July 31, 2004)	2	Few

The News Release is available at http://www.health.state.ny.us/press/releases/2005/2005-03-11_patient_safety_initiative.htm and from the Center for Medicare Advocacy, on request.

From *Enforcement*, March 2005, #21

4. IN LARGEST SETTLEMENT IN WISCONSIN FOR NURSING HOME VIOLATIONS, STATE ATTORNEY GENERAL SETTLES CASE WITH EXTENDICARE FOR $2.3 MILLION; $1.9 OF $2.3 MILLION REFLECTS AMOUNT PAID FOR CARE BETWEEN DECEMBER 2002 AND JULY 2004

"Life-threatening violations in an under-staffed nursing home" in Lakeside Nursing and

Rehabilitation were the basis for a $2.3 million settlement between the Wisconsin Attorney General and Extendicare. State of Wisconsin Department of Justice, "Extendicare Homes To Pay $2.3 M In Largest State Settlement Over Nursing Home Violations" (Feb. 19, 2005 News Release). The corporation agreed to pay the state, within ten days after judgment was entered by the court,

> . . . $356,459.40 in forfeitures previously imposed by the Department of Health and Family Services and an additional $1,917.026.10 . . . calculated to approximate the money Extendicare collected from its residents between December 2002 and July 2004, but did not use to provide care and treatment, which under the agreement reached today, cannot be kept.

The Attorney General's News Release, which "commended the Wisconsin Department of Health and Family Services, and Secretary Helene Nelson, for exemplary work in bringing the case to justice," cites numerous violations cited by the Department. Between January 29, 2002 and August 3, 2004, the Department issued 36 state and federal statements of deficiencies to Lakeside, involving bedsores, inadequate staffing, and deficient nurse aide training, among other problems.

The news release describes the corporation as

> . . . put[ting] its corporate profits ahead of the safety, health, and welfare needs of the people it pledged to take care of. While making sure all the beds at Lakeside were filled, Extendicare reduced Lakeside's overhead by limiting staff and reducing the delivery of necessary services.

The case was brought by the Medicaid Fraud Control Unit in the Attorney General's office.

Earlier news reports about the facility described "a series of regulatory problems in 2003 and 2004." "Chippewa Valley's largest nursing home faces potential sanctions," *Star Tribune* (Feb. 5, 2005). Between July 2003 and June 2004, state officials cited six immediate jeopardy deficiencies in the facility, "the most on record for a Wisconsin nursing home."

The most recent survey cited two additional immediate jeopardy deficiencies. On December 3, a "student nurse . . . failed to follow specifics in a feeding plan for one resident diagnosed with aspiration pneumonia, which is caused by inhaling food or vomit into the lungs." The resident experienced a number of coughing episodes and died from cardiac failure two weeks later.

> In the second case, a licensed practical nurse did not call a physician immediately after a resident with a history of falls was found on the floor in front on her recliner in a pool of blood. The woman complained of pain in her left shoulder but was not given pain medication.
>
> Another nurse who came on duty two hours later checked the woman and sent her to the hospital, which found the woman had several broken bones and multiple bruises to the face and shoulder.

Nursing Home Compare (visited on March 4, 2005) reports that the facility had 29 deficiencies,

including four immediate jeopardy deficiencies, as of its last inspection on May 26, 2004. The state average is four deficiencies per survey. Of the 15 quality measures, Lakeside did worse than the state average on eight

- activities of daily living (28% compared to 15% in Wisconsin);
- pain (14% compared to 6%);
- physically restrained (17% compared to 3%);
- depression/anxiety (20% compared to 15%);
- catheter (9% compared to 7%);
- ability to move in and around room got worse (13% compared to 12%);
- urinary tract infection (10% compared to 8%); and
- short-stay residents with pressure sores (17% compared to 15%).

On five measures, Lakeside did better than the state average:

- pressure sores, high risk residents (5% compared to 11%);
- pressure sores, low risk residents (2% compared to 3%);
- low-risk residents who lose control over bowels or bladder (36% compared to 43%);
- weight loss (6% compared to 8%); and
- short stay-resident with pain (23% compared to 27%).

On two measures, Lakeside did the same as the state average:

- residents spending most of their time in bed or chair (1%); and
- short-stay residents with delirium (4%).

The Attorney General's February press release is available at http://www.doj.state.wi.us/news/nr021905%5Fmdfr.asp; the article, at http://www.startribune.com/dynamic/story.php?template=print a&story=5224720. Both are available from the Center for Medicare Advocacy, on request.

From Enforcement, #24

Toby Edelman
May 10, 2005

Appendix 2

STATEMENT OF THE CENTER FOR MEDICARE ADVOCACY, INC.

TO THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

HEARING ON POST-ACUTE CARE

PRESENTED BY

TOBY S. EDELMAN
SENIOR POLICY ATTORNEY, CENTER FOR MEDICARE ADVOCACY, INC.

JUNE 16, 2005

Madam Chairwoman and Members of the Committee:

The idea of using a uniform assessment instrument for post-acute care has been discussed for many years.[1] As Congress has recognized, there are many potential benefits from using a single instrument. A single, comprehensive instrument might lead to more uniformity, more accuracy, and less confusion if it captured all relevant information about patients that health care providers needed in order to assure appropriate post-acute care for Medicare beneficiaries. Improved care outcomes for Medicare beneficiaries could result.

In addition to planning care for beneficiaries, however, another key purpose of a uniform assessment instrument is saving public money. It appears to make little sense to pay vastly different amounts for the same services, based solely on the setting of care. While this point has validity, we need to remember the unintended consequences of similar cost-containment efforts in the past. Costs shifted from one setting to another; uniform rates gave windfalls to some providers, eliminated other providers, and did not improve care for beneficiaries; and beneficiaries and providers lost the opportunity to make choices about health care.

Cost-shifting. Twenty years ago, Congress enacted a prospective payment system for acute care hospitals. One explicit purpose was reducing hospital costs. A considerable amount of research found, as expected, that hospital lengths of stay were reduced following the introduction of PPS. There is certainly a benefit to that result, in and of itself, both for public payment systems and for beneficiaries. But some less predictable and less beneficial results also occurred.

Research on the treatment of beneficiaries with hip fractures found enormous changes in care

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[1] Joan L. Buchanan, Ph.D., et al, "An Assessment Tool Translation Study," *Health Care Financing Review* 24(3): 45-60 (Spring 2003) (describing benefits from comparable measures across settings, but difficulties in developing a single assessment tool for long-term care); MedPAC, *Report to Congress: Medicare Payment Policy* 93 (March 2001) (noting

settings and costs following the implementation of PPS. One study found that before PPS, patients received rehabilitation in the hospital and generally went home, either directly from the hospital or following a short stay in a SNF. After PPS, hospital lengths of stay declined from 22 days to 13 days and the percentage of residents discharged to SNFs increased from 38% to 60%. The expectation was that patients could get the same rehabilitation services in SNFs that they had received in acute care hospitals, but at lower cost. This did not prove true. After PPS, the researchers found that, for various reasons, "rehabilitation therapy within the nursing homes was less effective than inpatient therapy before PPS." The outcomes for patients with hip fracture were worse following PPS. Instead of getting therapy and returning home, patients were more likely to be in the nursing home a full year after their hip fracture; a 200% increase in the rate of nursing home residence was reported by the study after PPS was implemented.[2] The researchers called this finding "alarming" and their most important finding. Services were not the same in the different settings.

Not only were care outcomes worse for beneficiaries with hip fractures following PPS, but expected cost savings also did not materialize as costs moved elsewhere. After PPS, people with hip fractures spent less time in the hospital, but these patients then became Medicare patients in SNFs and then, frequently, as the researchers found, long-term residents of nursing homes. Medicare payments to SNFs increased in the years following implementation of PPS for hospitals.[3] And

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1999 and 2000 MedPAC recommendations to develop a common core set of assessment data elements for post-acute care).

[2] John F. Fitzgerald, M.D., et al, "The Care of Elderly Patients with Hip Fracture," *New England Journal of Medicine* 319(21):1392-1397 (Nov. 24, 1988).

[3] MedPAC reported that Medicare spending in SNFs increased from $3.6 billion in 1992 to $13.5 billion in 2003. MedPAC, *A Data Book; Healthcare Spending and the Medicare Program* 142, Chart 9-2 (June 2004). Other factors also contributed to the growth in SNF care during this period, including new SNF coverage guidelines issued in 1988, enactment of the Medicare Catastrophic Coverage Act of 1988 (which revised rules for SNF coverage), and Medicare's use of cost-based reimbursement prior to 1998. "A Review of Issues in the Development and Implementation of the Skilled Nursing Facility Prospective Payment System" 2 (May 2004).

patients who would have gone home from the hospital now found themselves living in nursing facilities on a long-term basis, generally, as Medicaid beneficiaries. Savings in Medicare acute care hospital costs were accompanied by increases in Medicare and Medicaid post-acute costs. Costs shifted from one setting to another, with worse care outcomes for beneficiaries. Lessons learned from this experience are that lower-cost settings do not necessarily provide comparable services and that new health care costs may emerge in other settings.

The consequences of uniform rates: Recent experience in nursing home reimbursement following enactment of a prospective payment system in 1997 illustrates the consequences of establishing uniform rates. The PPS system for skilled nursing facilities eliminated the long-standing payment differential between Medicare reimbursement rates for free-standing and hospital-based SNFs. All SNFs now receive the same rates, based on the assessed needs of their residents. In developing these rates, the Centers for Medicare & Medicaid Services used both free-standing and hospital-based rates. When the rates were combined, hospital-based SNFs wound up with lower rates and free-standing SNFs got higher rates (i.e., the financial benefit of the higher rates that hospital-based SNFs had received). As a consequence of these changes, the Government Accountability Office has repeatedly found that free-standing facilities have increased their Medicare margins – from 8.4% in 1999 to 18.9% in 2000 – and hospital-based facilities have had extremely negative margins,[4] with 26% of the units closing between 1998 and 2000.[5]

Paying uniform rates across SNF settings did not assure that necessary care was provided to beneficiaries. In a series of reports, the GAO found that SNFs changed their care practices in

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[4] GAO, *Medicare Payments Exceed Costs for Most but Not All Facilities*, GAO-03-183 (Dec. 2002).

[5] "A Review of Issues in the Development and Implementation of the Skilled Nursing Facility Prospective Payment System" 29 (May 2004).

response to the PPS system so that residents received *less* therapy than before.[6] And SNFs failed to increase nurse staffing, despite a statutorily-mandated increase in the nursing component of the Medicare rates.[7] These reports demonstrate that reimbursement systems alone are not sufficient to assure that facilities provided appropriate care and services to Medicare beneficiaries. A strong regulatory system, with incentives that are consistent with, and complemented by the reimbursement system, is necessary.

Choice for beneficiaries: Generally, federal law guarantees beneficiaries the right to choose among post-acute providers that are certified to provide them with care. As long as the provider agrees to serve the beneficiary, the beneficiary can choose among providers.

As we think about a uniform assessment instrument, questions arise. Would such an instrument restrict beneficiary choice and limit beneficiaries to the least expensive care setting, regardless of beneficiary and provider choice to the contrary? Some years ago, beneficiaries in a western state were denied the right to choose a hospital-based SNF when a lower-cost free-standing SNF was available. Some beneficiaries objected when they were told they would have to move great distances from their families to a free-standing facility. Post-acute care, for many people, becomes a permanent placement. While people may choose *short-term* care in distant locations, they usually want to be near families and friends if a placement turns into the rest of their lives. An assessment instrument should not be used to limit beneficiary choice among appropriate post-acute providers.

Finally, do various post-acute settings *in fact* serve the same populations and provide identical services? The evidence is in conflict.

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[6] GAO, *Skilled Nursing Facilities; Providers Have Responded to Medicare Payment System By Changing Practices*, GAO-02-841 (Aug. 2002).

[7] GAO, *Skilled Nursing Facilities: Available Data Show Average Nursing Staff Time Changed Little after Medicare Payment Increase*, GAO-03-176 (Nov. 2002).

Some evidence indicates a clear overlap in the populations served by different post-acute care settings and in the services these settings provide. The increasing acuity of SNF residents is demonstrated by the proposed Medicare reimbursement rules for SNFs, published last month, which modify the 44 assessment categories and add nine new high-cost categories to reflect residents who are medically complex and also need rehabilitation.[8] On the other hand, some studies indicate that post-acute providers may serve different people or provide different intensities of services, or both.[9]

Geriatricians tell us that people become more different from each other as they age. The combination of various chronic and acute conditions and health care needs may make people with similar post-acute conditions different from each other in significant ways that justify different post-acute settings. While government payers do not want to pay for more expensive services when less expensive services would work equally well, older people may have different needs, or may suddenly and unexpectedly develop new needs, and require different settings as a result.

Assuring accurate and comprehensive assessments so that Medicare beneficiaries get the care and services they need in the appropriate setting of their choice is an important public goal of uniform assessments and could be an improvement over today's system. However, if paying the lowest rate possible is the primary public goal of uniform assessments, beneficiaries may not be served well and it may create a false sense of savings if costs are simply shifted elsewhere.

Thank you.

The Center for Medicare Advocacy is a private, non-profit organization founded in 1986, that provides education, analytical research, advocacy, and legal assistance to help elders and people with disabilities obtain necessary healthcare. The Center focuses on the needs of Medicare beneficiaries, people with chronic conditions, and those in need of long-term care. The Center provides training regarding Medicare and healthcare rights throughout the country and serves as legal counsel in litigation of importance to Medicare beneficiaries nationwide.

Toby S. Edelman is a Senior Policy Attorney with the Center for Medicare Advocacy in the Washington, DC office. Since 1977, she has represented and worked on behalf of nursing home residents. She was a member of the Medicare SNF Technical Advisory Panel that considered refinements to the Medicare SNF reimbursement system (2004).

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[8] 70 Federal Register 29070 (May 19, 2005).

[9] MedPAC, *Report to Congress: Medicare Payment Policy* 91-92 (March 2001).

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Appendix 3

July 3, 2003

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, 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.

No change in law or regulation is necessary. We seek only modifications 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.

This issue has now taken on a new importance, and Medicare access to and coverage of SNF care are jeopardized, in light of the Inspector General's recent demands 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.

Beneficiaries' access to care and services is jeopardized. Beneficiaries and SNFs should not be retroactively denied 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

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