

CMS-1545-P-1 Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008

Submitter : Mr. Scott Jones

Date & Time: 05/23/2007

Organization : Novartis Pharmaceuticals Corporation

Category : Drug Industry

Issue Areas/Comments

Consolidated Billing

Consolidated Billing

The Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities proposed rule for FY 2008, published in the Federal Register on May 4, 2007, invites comment on recent medical advances that might meet our criteria for exclusion from SNF consolidated billing. 72 Fed. Reg. 25525, 25556 (May 4, 2007). As we explain below, an innovative and highly effective osteoporosis treatment called Reclast? (zoledronic acid) Injection satisfies those criteria, and requires separate payment to ensure that Medicare beneficiaries are afforded full access to its unique benefits.

CMS-1545-P-1-Attach-1.DOC



Scott Jones
Vice President Health Policy

1
Novartis Pharmaceuticals
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May 23, 2007

BY ELECTRONIC DELIVERY

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

Re: CMS-1545-P; Consolidated Billing

Dear Sheila Lambowitz:

The Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities proposed rule for FY 2008, published in the Federal Register on May 4, 2007, invites comment on "*recent medical advances that might meet our criteria for exclusion from SNF consolidated billing.*"¹ As we explain below, an innovative and highly effective osteoporosis treatment called Reclast® (zoledronic acid) Injection satisfies those criteria and requires separate payment to ensure that Medicare beneficiaries are afforded full access to its unique benefits.

Impact of Osteoporosis on Medicare Beneficiaries

Bone fractures caused by osteoporosis exact an extraordinary and largely unrecognized human and financial toll. The Surgeon General warned recently in a special report on *Bone Health and Osteoporosis* that unless immediate action is taken by 2020 half of all Americans older than 50 will be at risk of fractures from osteoporosis and low bone mass. Today, 10 million Americans over the age of 50 have osteoporosis, while another 34 million are at risk of developing osteoporosis. Each year, about 1.5 million people suffer an osteoporotic bone fracture.

As the Surgeon General explained, hip fracture in particular frequently causes an elderly person's health to spiral downward. Twenty percent of elderly people who suffer a hip fracture end up in a nursing home within one year; and a hip fracture makes an elderly person four times more likely to die within three months. Hip fractures account for 300,000 hospitalizations each year.

Half of women over age 50 with osteoporosis will suffer an osteoporotic fracture within their lifetimes. Incidence of hip fracture in women is projected to rise 240% worldwide by 2050 as populations grow and age. The medical expense for treating broken bones from osteoporosis is as high as \$18 billion each year. The costs of long-term care and lost work add billions to this figure.

Background on Reclast

¹ 72 Fed. Reg. 25525, 25556 (May 4, 2007).

A new drug called Reclast®, currently being investigated by Novartis Pharmaceuticals Corporation (“Novartis”) for the treatment of postmenopausal osteoporosis, is the first once-yearly treatment that has been clinically proven to reduce significantly the incidence of bone fracture across the most common osteoporotic fracture sites. New Phase III data demonstrate that Reclast® is highly effective in reducing the incidence of hip and spine fracture—the most common fracture sites—in women with postmenopausal osteoporosis. The active ingredient in Reclast® is zoledronic acid. Reclast® belongs to a class of drugs called bisphosphonates and is administered via a once-yearly intravenous infusion.

A recent article in the *New England Journal of Medicine* concluded that patients treated with Reclast® remarkably experienced 70% fewer new spine fractures and 41% fewer hip fractures over a three year period than patients treated with placebo.² (A copy of this article is attached for your review.) The convenience of a once-yearly infusion will likely improve patient compliance over that of existing osteoporosis treatments. Moreover, over three quarters of study subjects preferred a yearly infusion over a weekly pill. Reclast® holds the potential to spare millions of elderly Americans premature death and disability and to save the health care system billions of dollars annually.

Reclast® was approved by the FDA in April 2007, to treat Paget’s disease. The PDUFA date for Reclast® concerning the treatment of Postmenopausal Osteoporosis is August 17, 2007.

Exclusion from Consolidated Billing

Under section 4432(b)(1) of the Balanced Budget Act of 1997 (BBA), the SNF consolidated billing provision applies to any beneficiary who “*is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations....)*” The Health Care Financing Administration (HCFA) interpreted this provision to “grant the Secretary the specific authority to define the concept of ‘services furnished to SNF residents’ further in regulations.”³ Pursuant to that authority, HCFA established that outpatient services, “*under commonly accepted standards of medical practice, lie exclusively within the purview of hospitals rather than SNFs, are not subject to Consolidated Billing, but are instead bundled to the hospital.*” Such services include “*cardiac catheterization, CT scans, magnetic resonance imaging, [and] ambulatory surgery involving the use of an operating room.*”⁴

The regulatory criteria for excluding specific services from the consolidated billing provision were further elaborated in the Balanced Budget Refinement Act of 1999 (BBRA). The BBRA targeted for exclusion “*high-cost, low probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] received under the prospective payment system.*”⁵

Reclast® Should be Paid Separately

Reclast® should be excluded from the SNF consolidated billing provision and paid separately under Medicare Part B. First, Reclast® will be a high-cost item. Although the final sales price for Reclast® has not yet been determined, it is likely to be considerably higher than a number of services that are already excluded from consolidated billing by statute or regulation, including CT, MRI, and

² Dennis M. Black, et al., “Once-Yearly Zoledronic Acid for Treatment of Postmenopausal Osteoporosis,” 356 *New England Journal of Medicine* 1809 (May 3, 2007).

³ 63 Fed. Reg. 26298 (May 12, 1998).

⁴ *Id.* at 26298-99.

⁵ 72 Fed. Reg. at 25556 (citing BBRA Conference Report (H.R. Rep. No. 106-479 at 854) (1999)).

certain dialysis supplies and equipment. Second, by definition Reclast® is administered infrequently—specifically, one time per year.

Because of these factors, Reclast is especially susceptible to underutilization by SNFs. SNFs have strong incentive to use other, less expensive treatments for osteoporosis that are *theoretically* as effective in reducing the incidence of bone fracture, albeit for a much shorter period of time. As the clinical investigators for the Health Outcomes and Reduced Incidence with Zoledronic Acid Once Yearly (HORIZON) Pivotal Fracture Trial recently reported in the *New England Journal of Medicine*, annual infusion of intravenous zoledronic acid achieved a 70% reduction in the vertebral fracture rate—far higher than the 40% to 50% reduction previously observed with weekly or monthly oral bisphosphonates. The investigators concluded that the greater effectiveness of once-yearly infusion was likely due to improved patient compliance:

A regimen of infusions once a year appears to ensure that patients will have a full treatment effect for at least 12 months. In contrast, many patients who receive prescription for oral bisphosphonates stop treatment, and most appear to be taking less than 80% of their prescribed pills by 12 months. Adherence to a regimen of oral bisphosphonates is challenging because the drug must be taken with a full glass of water when the patient is fasting, and the patient must remain upright for at least 30 minutes after taking the medication. Since poor adherence reduces the anti-fracture efficacy, a single annual infusion of zoledronic might improve such efficacy in clinical practice.⁶

Finally, because it is administered only once per year, there is no risk that excluding Reclast® from consolidated billing and paying it separately under Part B will encourage overutilization.

In order to ensure that Medicare beneficiaries who are residents of SNFs receive the benefits of this uniquely effective treatment for osteoporosis, it is therefore necessary to exclude Reclast from the SNF consolidated billing provision and to pay it separately under Part B.

Thank you for your attention to this important issue. We would welcome the opportunity to meet with you during the comment period to present additional clinical information on Reclast®.

Sincerely,

Scott Jones, MPA, MA.
Executive Director, Health Policy
Novartis Pharmaceuticals Corporation

⁶ Black, *supra* at 1818.

CMS-1545-P

Because the referenced comment number does not pertain to the subject matter for CMS-1545-P, it is not included in the electronic public comments for this regulatory document.

CMS-1545-P

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CMS-1545-P

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CMS-1545-P-5 Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008

Submitter : Mr. John Sullivan

Date & Time: 06/25/2007

Organization : Sisters of Mercy Health System

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1545-P-5-Attach-1.PDF



14528 S. OUTER FORTY ■ SUITE 100 ■ CHESTERFIELD, MO 63017

June 18, 2007

Leslie V. Norwalk, Esq., Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P. O. Box 8016
Baltimore, MD 21244-8016

Attention: CMS - 1545 – P – Proposed Changes to Skilled Prospective Payment System

The Sisters of Mercy Health System (Mercy) is a 19-hospital system operating in Missouri, Kansas, Oklahoma, and Arkansas. We operate distinct part Skilled Nursing Facilities in 4 hospitals, and 3 hospitals have Swing Beds, which are paid under the Skilled Prospective Payment system. The Sisters of Mercy Health System welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "*Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008*" Vol 72 Fed. Reg. No. 86 (May 4, 2007).

Annual Update

We support CMS's proposal to utilize updated wage index data exclusive of the occupational mix adjustment, and the proposal to revise and rebase the SNF market basket to the FY 2004 based market basket.

Market Basket Index

Mercy does not agree with CMS's proposal to raise the threshold for forecast error adjustments, under the SNF PPS system, from .25 percentage points to .50 percentage points. Mercy believes that every forecast error, however small, should be corrected. Forecast errors published in recent Federal Registers reflect errors of .20 percentage points in FY 03; .10 percentage points in FY 04; .10 percentage points in FY 05; and .30 percentage points in FY 06. With the continuing trend of inaccuracies, resulting in underpayments to providers we feel that the current .25 percentage points is the maximum amount hospital based providers can absorb. We respectfully request CMS maintain the current forecast error threshold at .25 percentage points.

Thank you for considering our comments. Should you have any additional comments please contact Ron Trulove at (314) 364-3561 or me at (314) 628-3714.

Sincerely,

A handwritten signature in black ink that reads "John Sullivan". The signature is fluid and cursive, with a long horizontal stroke at the end.

John Sullivan,
President/CEO
Sisters of Mercy Health System

cc: Jim Jaacks
Randy Combs
Ron Trulove

**CMS-1545-P-6 Medicare Program; Prospective Payment System and Consolidated
Billing for Skilled Nursing Facilities for FY 2008**

Submitter : Mr. Edward Karlovich

Date & Time: 06/27/2007

Organization : UPMC

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Please see the attached letter with our comments

CMS-1545-P-6-Attach-1.DOC

#6

June 19, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Mail Stop: C4-26-05
Baltimore, MD 21244-1850

Via: UPS Delivery and
<http://www.cms.hhs.gov/eRulemaking>

ATTENTION: CMS-1545-P

RE: CMS-1545-P
Medicare Program; Prospective Payment System and Consolidated Billing for
Skilled Nursing Facilities for FY 2008; Proposed Rule
(Federal Register/Vol.72 No.86/May 4, 2007 pages 25526-25600)

Dear Sir or Madam:

On behalf of the University of the Pittsburgh Medical Center (UPMC) we are submitting one original and two copies of our comments regarding the Center for Medicare and Medicaid Services (CMS) proposed rule (Federal Register / Vol. 72, No. 86 / May 4, 2007 pages 25526 - 25600) "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008". We also are submitting these comments electronically to <http://www.cms.hhs.gov/eRulemaking>.

The following summarizes our comments and concerns regarding these proposed changes to the consolidated billing for Skilled Nursing Facilities (SNF's) for FY 2008 and beyond, and why we urge CMS to withdraw some of the proposed rules.

[CMS Proposal to Increase the Forecast Error Thresholds for FY 2008 and FY 2009 \(FR page 25530\)](#)

Proposed CMS Rules FY 2008 & Beyond: CMS has proposed significant increases in the current forecast error thresholds for FY 2008 and FY 2009 as follows:

- FY 2008 – CMS proposes raising the threshold for triggering a forecast error adjustment under the SNF PPS from the current 0.25 percentage point threshold to 0.50 percent.
- FY 2009 – CMS is also considering a higher threshold for the forecast error adjustment up to 1.0 percentage point for FY 2009.

The reason cited by Medicare (FR 5-4-2007 page 25530) for this proposed forecast error threshold policy change increase is as follows:

‘...it is now appropriate to draw a distinction between the kind of exceptional, unanticipated major increases in wages and benefits that initially gave rise to this policy and the much smaller variances between forecasted and actual change that more typically occur from year to year, in recognition that a certain level of imprecision is inherently associated with measuring statistics. In general, the SNF market basket is expected to reasonably project inflationary price pressures. Further, according to MedPAC analysis, we note that freestanding SNF’s (which represent more than 80 percent of all SNF’s) have received Medicare payments that exceeded costs by 10.8 percent or more since 2001, and Medicare margins are projected to be 11 percent in 2007.’

Response: UPMC respectfully disagrees with the higher forecast error thresholds proposed by CMS for FY 2008 (from current 0.25% to 0.50%) and the even higher threshold level being considered for FY 2009 (up to 1.0%). UPMC urges CMS to maintain its current market basket forecast error threshold of 0.25 percent, or adopt an annual forecast error to actual adjustment for the following reasons:

- *Current 0.25% Forecast Error Threshold Seems More Than Adequate While a 0.5% or 1.0% Forecast Error Threshold Seems Excessive and Unreasonable – The current forecast error threshold is 0.25% and the historic average SNF market basket is 3.2% as based on the last 5 years published in the May 4, 2007 Federal Register page 25555. This equates into a current error rate of 7.8% ($0.25 / 3.2 = 7.8\%$). The error level proposed for FY 2008 of 0.50 equates to a 15.6% error rate ($0.50 / 3.2 = 15.6\%$) and a 1.0% threshold under consideration for FY 2009 equates to a 31.2% error rate ($1.0\% / 3.2\% = 31.2\%$).*

It does not seem reasonable that Medicare would propose increasing the market basket error rate threshold beyond the 0.25 % level since as noted above this is an annual Medicare savings of 7.8 % of the annual inflator. Since the Medicare market basket index methodology has generally understated the actual SNF market basket index in recent years, a savings of 39% of the annual inflation factor would be generated over a five year period ($5 * 7.8\% = 39\%$). To double that level as proposed for FY 2008 to 0.50% is the equivalent of 78% inflation savings over a five year period. The even higher threshold of 1.0% being considered by CMS for FY 2009 would equates to 156% inflation savings over a 5 year period. We do not support any of these proposed rules to increase the market basket forecast error thresholds in either FY 2008 or FY 2009. Instead we urge CMS to either keep the forecast error threshold at its current 0.25% level or to require a forecast error adjustment to actual, every year. The mere existence of this annual forecast error threshold provides Medicare with a built-in minimum savings benefit that SNF providers cannot recover. The SNF’s are then forced to face the full market basket price changes with inadequate payment levels. This is especially true for hospital-based SNF’s which according to a recent MedPAC report (March 2007, page 178) indicated that hospital-based SNF’s have negative Medicare profit margins of approximately 85%. We urge CMS to withdraw this

proposal or to be fair to all SNF providers adopt the policy of an annual correction adjustment which would take the overstatement or understatement of previous years forecast error projections to actual and factor them into the current annual update.

- Medicare also indicated that the forecast error threshold should be increased because approximately 80% of the freestanding SNF's are making a profit margin of approximately 10.8% from Medicare. The proposed rule however, does not indicate the large losses that hospital-based SNF's are having (- 85 percent) according to a recent 2007 MedPAC report. At this time we would urge CMS to modify the SNF RUG's to better recognize the higher non-therapy ancillary costs that hospital-based facilities incur; to develop an outlier policy for exceptionally costly stays and to consider an add-on payment for hospital-based SNF's which are being underpaid.

Conclusion

We appreciate the opportunity to submit these comments on your proposed changes to the "Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008; Proposed Rule" and hope they are considered before any final rule is adopted.

Sincerely,

Edward Karlovich
Chief Financial Officer
Academic and Community Hospitals

CC: Concordia, Elizabeth
Farner, David M.
Huber, George
Kennedy, Robert A.
Lewandowski, Christine
Stimmel, Paul
System CFO's

CMS-1545-P-7 Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008

Submitter : Mr. Thomas Jendro

Date & Time: 06/27/2007

Organization : Illinois Hospital Association

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-1545-P-7-Attach-1.DOC



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Chicago Heights

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Chicago

David Ochs
Pontiac

David Schertz
Rockford

Connie Schroeder
Pittsfield

June 27th, 2007

Ms. Leslie Norwalk, Esq.
Acting 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-1545-P

Re: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008; Proposed Rule, Federal Register, Volume 72, No. 86, Friday, May 4, 2007

Dear Ms. Norwalk:

On behalf of our approximately 200 member hospitals and 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 hospital inpatient skilled nursing facility services for fiscal year 2008. Therefore, in accordance with instructions in the rule, the Illinois Hospital Association presents the following comments for your consideration:

BACKGROUND:

- **Forecast error adjustment:** A forecast error percentage (measuring the difference between estimates of the market basket increase and the actual market basket increase) of 0.25% is currently used to determine whether an adjustment to the overall skilled nursing market basket increase is required. CMS proposes to increase that percentage difference to 0.50%, primarily to eliminate "minimal imprecision" in the data. CMS' own analysis indicates that the percentage difference in FY 2006 is 0.3%, high enough to justify an adjustment under the current rules, but too low to justify it under the proposed rule. Whether the percentage adjustment is 0.25%, 0.50% or an amount in between, payments to skilled nursing providers are significantly impacted. **Therefore, the Illinois Hospital Association recommends that CMS defer any revisions to the market basket forecast error adjustment to at least FY 2009, but also, because the data is currently available, adjust for the 0.3% "underpayment" in the FY 2008 final rule SNF base per diem rates.**

Ms. Norwalk, thank you again for the opportunity to comment. The Illinois

Hospital Association also welcomes the opportunity to work with your agency in the continued development and refinement of the Medicare payment system for all providers.

Sincerely,

Thomas A. Jendro
Senior Director-Finance
Illinois Hospital Association
(630) 276-5516
tjendro@ihastaff.org

Submitter : Mr. Glenn Hackbarth
Organization : Medicare Payment Advisory Commission
Category : Federal Government

Date: 06/28/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1545-P-8-Attach-1.PDF



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

June 27, 2007

Leslie V. Norwalk, Acting 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-1545-P

Dear Ms. Norwalk:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled *Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008*, Federal Register, Vol. 72, No. 86, p. 25526 (May 4, 2007). We appreciate your staff's ongoing efforts to administer and improve the payment system for skilled nursing facilities, particularly given the agency's competing demands.

The proposed rule updates the rates by 3.3 percent (the market basket), in accordance with current law. In March 2007, MedPAC recommended to the Congress that the industry receive no update given that the aggregate Medicare margin in 2005 was 12.9 percent and the estimated margin for 2007 was 11 percent. We concluded that SNF payments would be more than adequate to accommodate cost growth without an update.

The proposed rule revises and rebases the SNF market basket to reflect more recent cost information. Since current payments reflect SNFs' cost structures in 1997, updating the market basket will help make payments more accurate. The revisions include a methodology to estimate Medicare-allowable costs (instead of reflecting the costs of the entire facility), which will make the SNF market basket consistent with those used in other PPSs.

We have two concerns with the proposed rule: the triggering of a forecast error correction and the lack of further refinements to the PPS despite acknowledged shortcomings in the SNF PPS.

First, the Commission believes that the market basket and projection should be as accurate as possible. We agree with CMS that corrections should fix major errors and appreciate the proposal to increase the threshold to screen out small adjustments that are likely to occur with any projection and would

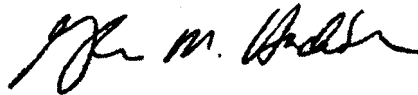
probably smooth out over time. That said, we do not support the triggering of an automatic correction. The Commission bases its recommended updates to payment rates on multiple factors, including the financial health of the industry. Automatic adjustments are a particular concern when coupled with automatic market basket increases—and the current circumstances of the SNF industry provide a good example of the problem. An automatic payment update coupled with an automatic forecast correction would result in making a payment increase on top of legislated increases to the payment rates, even when the industry has sizable Medicare margins.

Our second concern centers on what the proposed rule does not address. MedPAC is disappointed that the proposed rule does not correct major shortcomings in the design of the SNF PPS. Two years ago we commented that the proposed refinements now in place were inadequate because they (a) did not directly target payment for nontherapy ancillary services (NTAs), and (b) continued to base a large portion of the daily payment on the amount of therapy provided or expected to be provided. CMS-sponsored research has identified three areas of potential refinements: developing an NTA component, moving away from a service-based therapy component, and adding an outlier policy. Such refinements could improve the accuracy of payments and reduce incentives to furnish services of marginal value, and would not require the collection of new information. In the agency's report to the Congress, CMS noted that it would continue to investigate alternatives to the RUG system. We urge CMS to complete its review so that necessary improvements to the PPS can be made.

Over the coming year, MedPAC will develop and evaluate alternative designs for the SNF PPS. We plan to use the work conducted by the Urban Institute for CMS as a starting point in our examination of design options. We will keep CMS abreast of this work and welcome the agency's input.

If you have any questions or require clarification of our comments, please feel free to contact Mark Miller, MedPAC's Executive Director.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Glenn M. Hackbarth
Chairman

Submitter : Ms. Patricia Blaisdell
Organization : California Hospital Association
Category : Health Care Provider/Association

Date: 06/28/2007

Issue Areas/Comments

GENERAL

GENERAL

see attachment

CMS-1545-P-9-Attach-1.PDF



**CALIFORNIA
HOSPITAL
ASSOCIATION**

Hospital Services
for Continuing Care

June 29, 2007

Leslie V. Norwalk, Acting 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: CMS-1545-P: Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2008; Proposed Rule

Dear Ms. Norwalk

The California Hospital Association (CHA) respectfully submits comments on the proposed rule for skilled-nursing facility (SNF) prospective payment system (PPS) refinements for Federal fiscal year (FY) 2008. CHA submits comments on behalf of its nearly 500 hospital and health system members, including approximately 130 hospital-based skilled nursing facilities.

The proposed rule does not include major policy revisions or changes to reimbursement methodology. It includes annual payment rate updates, as well as proposed changes to the market basket index. In addition, CMS requests comments regarding the consolidated billing requirement and additional procedures that may be appropriate for exception. CHA appreciates the opportunity to comment on these items.

The Role of Hospital-Based SNFs

Hospital-based SNFs play a unique role in the continuum of care provided to Medicare patients. Hospital-based facilities care for patients who are moved out of the acute hospital because they are “stable,” but who continue to need specialized care. These patients need access to the technology, treatment modalities and clinical resources found in hospitals.

Examples of the services these patients require include intravenous (IV) drug therapy, total parenteral nutrition, psychiatric evaluation, complex pain management, pharmaceutical consultation, hemodialysis, radiation, chemotherapy, complex discharge planning due to life-changing events, and complex social service intervention.

Market Basket Update

The proposed rule recommends a full market basked update of 3.3 percent, based on the revised and rebased market basket update. CMS also notes that the President’s FY 2008 budget, as well as the Medicare Payment Advisory Commission (MedPAC), proposed a zero percent update, but that current law requires that a full market update be implemented.

CHA supports the full market update for hospital based skilled nursing facilities. MedPAC data reveals that the financial performance of hospital-based and free-standing SNFs is very different: In 2005, the aggregate Medicare margin for hospital-based facilities was negative 85 percent, as compared to an aggregate of positive 13 percent for free-standing facilities. This large difference in margins has existed since the implementation of SNF PPS. Furthermore, these unsustainable negative margins have led to the closure of numerous hospital-based skilled nursing facilities at a time when demand for such services continues to increase. According to the California Health Care Foundation, the number of beds in hospital based nursing homes decreased by 50 percent between 2000 and 2004.

In addition to supporting the full market basket update, CHA urges CMS to consider additional modification to the payment system that adequately recognizes the specialized care provided in hospital based SNFs, and support the higher staffing and ancillary costs of the services that such care requires. Although the market basket update appears acceptable, California facilities are not expected to fully benefit from it because of a compression to the wage related portion. CMS should consider delaying the implementation of the forecasting error threshold, or even consider discontinuing it all together.

Outlier Pool

As we have previously suggested, CHA also encourages CMS to create an outlier pool equal to 2 percent to 3 percent of SNF payments. With new developments in medications and medical therapies, the need for an outlier is pressing. As has been noted in the past, some complex and high-acuity patients have difficulty finding a SNF that will admit them, and are forced to stay in an acute-care hospital unnecessarily. Given that all other PPSs in the Medicare program include an outlier policy, we believe that the SNF PPS should also.

Consolidated Billing

In the current proposed rule, CMS invites comments on consolidated billing, including suggestions for additional procedures for exclusion from consolidated billing. CHA appreciates the interest and willingness of CMS to stay current with advances in medical treatment and technology.

We encourage CMS to examine other areas of SNF patient care, in addition to the four areas that have been identified previously (chemotherapy items, chemotherapy administration services, radioisotope services and customized prosthetic devices). Specifically, we encourage CMS to consider the development of guidelines for the exclusion of certain specialized and highly technical wound care procedures, including hyperbaric oxygen treatment for exclusion from consolidated billing.

Dialysis

California hospitals are seeing an increasing number of patients who have complex medical needs and require dialysis, but are otherwise stable. These patients could be cared for by nursing

facilities. Because of current Medicare coverage interpretations, however, these patients often remain in the hospital intensive care unit needlessly. As stated in CHA's letter to CMS dated May 3, 2005, on the proposed rule regarding conditions for coverage of end-stage renal disease facilities, we urge CMS to make it financially feasible for nursing facility patients to receive dialysis at the bedside from a dialysis facility or a SNF.

Thank you for the opportunity to provide comments on this proposed rule. If you have any questions or would like to discuss our comments, please contact Pat Blaisdell at (916)552-7553, or pblaisdell@calhospital.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Pat Blaisdell", with a long horizontal flourish extending to the right.

Patricia L. Blaisdell

Vice President, Hospital Services for Continuing Care