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June 27, 2011

Donald M. Berwick, M.D., Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW, Room 314-G
Washington, DC 20201

Subject: AHCA Comments on CMS FY 2012 SNF PPS NPRM [CMS-1351-P]

Dear Administrator Berwick:

The American Health Care Association (AHCA) appreciates the opportunity to comment on the CMS proposed rule, ***Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Disclosures of Ownership and Additional Disclosable Parties Information,*** 76 *Federal Register, 26364, (May 6, 2011).*

We are the nation's largest association representing long term and post-acute care providers. Our 11,000 members include profit and not-for-profit skilled nursing facilities, assisted living residences, sub-acute centers and homes for people with developmental disabilities.

The CMS FY 2012 Skilled Nursing Facility Prospective Payment System (SNF PPS) proposed rule is an annual occurrence, but this year, it comes at a critical time. The Affordable Care Act (ACA) is a significant piece of legislation, making substantial changes that will reshape the utilization and delivery of health services. It offers the opportunity for better access to affordable care, improved quality of care, and better patient outcomes, all the while reducing costs. ACA driven reforms are slowly putting the pieces in place for major changes in the delivery of and payment for care through the Medicare program – both acute and post-acute. AHCA continues to be supportive of the goals of health care reform and assist its members in preparing for implementation.

Unfortunately, the FY 2012 SNF PPS would cause considerable harm to the SNF sector and the quality care it provides to millions of Americans each year. A reduction of $4.47 billion, coupled with additional Resource Utilization Group (RUG) system changes estimated in the billions and increased costs in the hundreds of millions of dollars, are of great concern. Implementing these adjustments all at once could threaten the financial stability and viability of the SNF sector, and therefore, its ability to continue to provide quality care.

The $4.47 billion cut would also have a significant impact on the economy and our recovery from the recession. Economic impact models suggest that the total effect of the proposed cut could put over 100,000 jobs at risk, reduce wage and salaries by about $5.0 billion, cut state and federal tax revenues by $1.6 billion, and decrease Gross Domestic Product (GDP) by about $12.5 billion.

This is particularly troublesome as states are currently grappling with extraordinary budget deficits and are already underfunding nursing facilities for Medicaid patients by over $5.6 billion annually. Many of America's nursing homes depend on Medicare to help bridge the gap for this enormous shortfall in order to cover their operational costs. The proposed FY 2012 SNF PPS would jeopardize the ability of facilities to continue to serve those on Medicaid – the frail, elderly and disabled.

AHCA supports CMS' efforts to modify the current Resource Utilization Group (RUG) classification system (RUG-IV) in a budget neutral manner. We also believe that CMS should implement in a budget neutral manner the various technical changes to the RUG system that are described in this year's proposed rule.

AHCA agrees that expenditures under the new RUG-IV system appear to be higher than they would have been under the previous system. AHCA supports CMS efforts to correct for this apparent shift on a prospective basis. The critical questions that remain are in determining budget neutrality and the appropriate correction factor, and in what manner it should be achieved.

Fortunately, there is a course to budget neutrality that meets the objectives of both CMS and the profession. CMS aims to achieve budget neutrality within the Medicare payment system to SNFs beginning October 1, 2011, and continuing thereafter. The profession's objective is that the adjustment occurs in a measured way to prevent exceeding budget neutrality and avoid jeopardizing patient care and the sector. AHCA believes both objectives can be met.

AHCA fully appreciates the challenges CMS faces in calculating its proposed adjustments for budget neutrality. Although we have concluded that there is no definitive way to settle on an accurate number at this time, we hold to our assertion that CMS has overestimated the size of the overpayment noted in the proposed rule.

The process for achieving budget neutrality is complicated by several factors which we fully explain in our attached detailed comments. We imagine staff at CMS encountered the same challenges our organization has in ascertaining a precise figure needed for reduction. These challenges include a lack of actual expenditure data; basing parity adjustment calculations on data for only part of a year; a downward bias in the technique utilized to compute payments under the previous system; and a failure to adjust for changes in the RUG-IV SNF PPS introduced in this year's proposed rule that will bring payments under the revised RUG-IV payment system closer to budget neutrality.

None of this is anyone's fault. The inability to determine an accurate number to reach budget neutrality at this time reflects the inherent complexity involved changing both the MDS and the RUG system, especially when those changes occur simultaneously.

Fortunately, there is a solution to the Medicare payment system to SNFs that does not require an educated guess. This solution assures budget neutrality from October 1, 2011, forward; presents the opportunity to calculate the correct figure for reduction; and prevents an unmanageable jolt to the sector.

AHCA is proposing the following:

- For FY 2012, CMS should reduce rates by 3.0 percent, plus the productivity adjusted market basket update.
- For FY 2013 and subsequent years, if necessary, CMS could further reduce rates up to 3.0 percent plus the productivity adjusted market basket update until budget neutrality is achieved.
- In determining budget neutrality, CMS should evaluate and include the impact of the various changes to the SNF PPS RUG system described in the FY 2012 proposed rule (e.g. changes to assessment reference date periods and grace days, allocation of group therapy minutes, implementation of the change of therapy (COT) other Medicare resident assessments (OMRAs), introduction of the end of therapy – resumption (EOT-R) OMRA, changes to the EOT OMRA, etc.). AHCA believes there could be Medicare payment reductions totaling hundreds of millions of dollars from potential changes in group therapy, as well as potential savings from other changes in the proposed rule, and ask that they are credited against potential reductions.
- If this phase of the budget neutrality adjustment results in overpayments in FY 2012 and beyond CMS should prospectively recover these non-budget neutral overpayments.

We believe our proposal offers several advantages for all those impacted by this decision. CMS will not be forced to estimate the amount needed to return to budget neutrality, assuring the agency that it will reach its ultimate goal. Additionally, the long term and post-acute care sector can absorb the phased-in reduction while maintaining the level of care our patients deserve. Finally, the economy will not experience the negative impact an 11.3 percent Medicare cut would have on the 10th largest employer in the country as it continues to cope with deep, multiple Medicaid cuts.

CMS has a long history of phasing-in negative adjustments to payment rates for many categories of providers and under circumstances far less harmful than the proposed 11.3% cut. CMS' practice looks to criteria such as improved accuracy of the proposed payment reduction, the potential for financial harm and disruption, and impact on access to care.

In addition to our discussion of the parity adjustment, our detailed comments include recommendations for improving upon CMS' proposed changes to group therapy, and on a host of other issues of critical importance to the Medicare beneficiaries that we all serve.

There are many points of discussion in these comments, but our position is relatively simple. AHCA agrees that SNFs were likely overpaid in FY 2011 due to the implementation of MDS 3.0 and RUG reforms. We accept that we cannot calculate an exact amount of the over payment. To prevent an over correction, AHCA proposes a measured response to protect the sector, our residents and the economy.

Additionally, when analyzing what constitutes budget neutrality, it is critical to credit any savings that occur from RUG system changes in the proposed rule. If the Government takes both an 11.3 percent parity adjustment and extracts hundreds of millions out of the sector through other proposed RUG system changes, there will be enormous damage to the financial viability of and the care provided by skilled nursing facilities. Finally, AHCA wants to ensure CMS achieves its goal of returning to a budget neutral payment system; therefore, it should receive any overpayment from the system beginning October 1, 2011 through prospective rate reductions.

Please do not hesitate to contact me should you have any questions or concerns. AHCA is willing and ready to assist CMS in any way we can to improve the system in order to benefit all of those involved - beneficiaries, providers, CMS and the Medicare program. We know the challenges before us are great, and we want to be part of the solution.

Sincerely,

Mark Parkinson
President and CEO

Executive Summary

The lingering uncertainty with the nation's economy only adds to the significance of the Centers for Medicare & Medicaid Services' (CMS') Skilled Nursing Facility (SNF) Prospective Payment System (PPS) proposed rule for Fiscal Year 2012 (FY 2012). Implementation of the *Affordable Care Act (ACA)* will reshape the utilization and delivery of health services in the U.S. and promises better access to affordable care, improved quality of care, and better patient outcomes, while reducing costs. Already we are seeing *ACA*-driven reforms pave the way for major changes in care delivery and payment for care of Medicare beneficiaries in both the acute and post-acute care settings. Despite our reservations with certain aspects of *ACA* implementation, the American Health Care Association (AHCA) maintains its support for the goals we all share regarding health care reform.

While health care reform did not fundamentally address the delivery of long term and post acute care (LTPAC) services, AHCA is pleased that CMS has recognized the importance of LTPAC in helping to achieve many of the reform goals set out in the ACA. We were glad to see that the recent proposed rule on Medicare Shared Savings Programs recognized the importance of LTPAC in meeting beneficiary needs and reducing Medicare program costs through reduced rehospitalizations and allowed for the participation of SNFs in Accountable Care Organizations (ACOs AHCA also appreciates that future demonstration projects and pilots will examine how LTPAC can help to further health care reform objectives. A steadfast advocate for improving the health, functionality, and quality of life for Medicare and Medicaid beneficiaries, AHCA stands ready to partner with the Administration and CMS in reforming and improving the delivery of health care services for America's seniors and people with disabilities.

Today's nursing homes are far different from their predecessors. We are proud that our patients are returning home more often and more quickly then ever before, even as SNFs now provide more intensive services to an increasingly elderly, frail and disabled population. SNFs also play a key role in not only rapidly rehabilitating and returning patients with the highest level of functionality to their homes in the community typically in a month or less.

As proud as we are of providing America's seniors with the highest quality of care, we are equally proud that our members do so at a much lower cost to the Medicare program than other institutional care settings, which in turn is helping to bend the health care cost curve.

Discussion

I. Challenges To Stable LTPAC Funding And Quality Improvement: Medicare and Medicaid

The financial viability of the long term and post-acute care sector is precarious. Profit margins for nursing facilities are thin – an estimated 1.2 percent based on Medicare cost report data for FY 2009 – the lowest among all health care provider types. With close to 80 percent of patients relying on Medicare or Medicaid to pay for the care they need, nursing facilities cannot easily recoup cost increases that other providers may be able to pass along to the consumer. On any given day, approximately 63.5 percent of nursing facility residents rely on Medicaid, and 14.4 percent of \residents have Medicare as the primary payer of the nursing and rehabilitation services they receive. Compounding the financial challenges nursing homes must address is chronically poor reimbursement by State Medicaid programs. Medicaid payments in most states are insufficient to cover the costs of services for Medicaid residents with a national average loss of $17.33 per day for each Medicaid patient. In 2010 alone, Medicaid underfunded nursing home care by approximately $5.6 billion nationwide.[1] The outlook for Medicaid reimbursement for nursing facility services doesn't look any better. Given the unprecedented number of state budget deficits, and federal stimulus funding due to expire less than a week after the comment period for the SNF PPS NPRM for FY 2012 closes, Medicaid reimbursement for nursing facility services will likely remain flat or be reduced in the short term.

Historically, Medicare has served an important role by cross-subsidizing chronic underfunding by Medicaid. Such cross-subsidization occurs in most health care settings where losses related to the treatment of one category of patients are underwritten by payments generated by treating another category of patients. Cross-subsidization in hospitals can be seen across departments, and most importantly, in viewing payments from public and commercial payers. The cross-subsidization that occurs across government payers in the long term and post-acute care setting echoes the same dynamics and operational realities as hospitals experience.

Certainly, one entitlement subsidizing another does not represent good, long-term public policy; however, it is a current reality and necessity to help ensure the adequacy and quality of patient care provided to the elderly, frail, and disabled residents in our nation's nursing homes. Even with the cross-subsidization of payments, Medicare margins are not sufficient to compensate for the growing shortfall in State Medicaid reimbursement.[2] On behalf of all those who care for such vulnerable patient populations, AHCA asks for CMS' help in addressing this vexing Medicaid underfunding of this essential care.

Adding to the seemingly intractable problem of Medicaid underfunding are the , proposed changes in the CMS FY 2012 SNF PPS Notice of Proposed Rule Making (NPRM) that would reduce SNF reimbursement rates by 12.6 percent or $4.47 billion for FY 2012. Such a massive reduction, which CMS considers a recalibration of the SNF PPS RUG-III to RUG-IV expenditure parity adjustment, threatens to destabilize the financial viability of the SNF sector as

[1] Eljay, LLC. *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, December 2010.
[2] Analysis by Eljay LLC (op cit) estimated that the shortfall for the two programs combined was about $2.5 billion in 2010.

it would effectively reduce SNF payments over the next decade by close to $60 billion. Moreover, numerous other proposed changes to the SNF PPS (*e.g.,* allocation of group therapy minutes, new change-of-therapy other Medicare required assessments, or tightened assessment reference date windows) will increase provider costs and reduce payments even further. Taken together, AHCA is projecting that this proposed rule would reduce SNF payments by roughly $90 to $100 billion – more than 3 times estimated Medicare program payments to SNFs for the current year.

The economic impact of the proposed 12.6 percent cut to long term care providers could be substantial. Preliminary AHCA analysis, using the Minnesota IMPLAN group economic impact simulation model, indicates that a $4.47 billion cut in long term care facility revenue for FY 2012 could put more than 120,000 full and part time jobs at risk, reduce labor income (wages and salaries) by about $5.0 billion, and subsequently reduce the nation's Gross Domestic Product (GDP) by close to $12.5 billion when factoring in the direct, indirect, and induced effects. Additionally, state and federal tax revenue is projected to be reduced by about $1.6 billion.

The economic modeling AHCA has conducted to date suggests – in addition to overestimating the size of the proposed budget neutrality recalibration – CMS is underestimating the costs and revenue shortfall from other proposed changes in the NPRM. Cuts of this magnitude and policy induced changes, which increase costs and reduce productivity, put the financial viability of the long term and post-acute care sector at risk, along with creating potential savings for the Medicare program. AHCA implores CMS to look beyond such obvious economic concerns, and toward our shared responsibility to ensure Medicare beneficiaries' continued access to skilled nursing and post-acute care that contributes to their health, functionality, and quality of life.

II. Keeping Parity Adjustment Budget Neutral Is Key To Stable Funding And Financial Viability

- ***CMS should implement changes to the SNF PPS RUG system in a budget neutral manner***

As we have noted in previous comments, AHCA has been supportive of CMS' goal to implement modifications to the SNF PPS in a budget neutral manner. Whether it was the transition from RUG-44 to RUG-53 in FY 2006 or the transition from RUG-III to RUG-IV in FY 2011, AHCA believes that such changes to the SNF PPS RUG system should be implemented in a budget neutral manner so as to maintain the stability and financial viability of the SNF sector and ensure that Medicare beneficiaries continue to have access to high quality skilled nursing and therapy services.

- ***CMS should phase-in budget neutrality adjustments to the SNF PPS RUG system***

AHCA is sympathetic to the challenges CMS must face maintaining budget neutrality while implementing changes to the SNF PPS RUG system, particularly when those changes radically realign its design, modify its underlying structure, and influence provider incentives. Still, AHCA has serious reservations regarding the accuracy and magnitude of CMS' proposed

recalibration of the parity adjustment, especially as the agency implements other changes to the SNF PPS RUG system that could affect its calculus for budget neutrality. As detailed below, AHCA urges CMS to use a phased-in approach to implementing the recalibration of the parity adjustment to get it "right," while avoiding inadvertently introducing changes that could destabilize the financial viability of the SNF sector during these fiscally challenging times.

Phasing in any payment reduction is consistent with CMS' longstanding practice of staging significant payment reductions to "moderate" the effects of payment reductions in many provider categories.

Indeed, in the current proposed rule for inpatient hospital PPS published on May 5, 2011, CMS confirms that "[i]t is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year." As illustrated in Appendix C, multi-year phase-in periods have been used to allocate reductions of less than one percent to four percent of the total estimated Medicare payment reductions under the relevant Medicare payment system. This range is well below the 12.6 percent reduction being proposed now for the SNF PPS.

As discussed below, a review of CMS' prior use of phase-in periods demonstrates that CMS generally consider three different factors in determining whether a phase-in period of delay is appropriate to "moderate" a proposed payment reduction or other policy change:

- Whether additional data and/or analysis could improve the accuracy of the proposed payment reduction;
- Whether the proposed payment reduction could cause financial harm or other disruptive effects to providers; and
- Whether the proposed payment reduction could affect access to care.

AHCA maintains that each of these factors is relevant to the current situation. Proper consideration of these factors provides CMS with more than sufficient justification for using a phase-in period for the proposed Medicare payment reduction.

III. Phased-In Approach to Recalibration of Parity Adjustment Needed for Budget Neutrality

- ***CMS should investigate and resolve data and methodology issues with the agency's calculation of the parity adjustment and re-estimate the recalibration of the parity adjustment for budget neutrality***

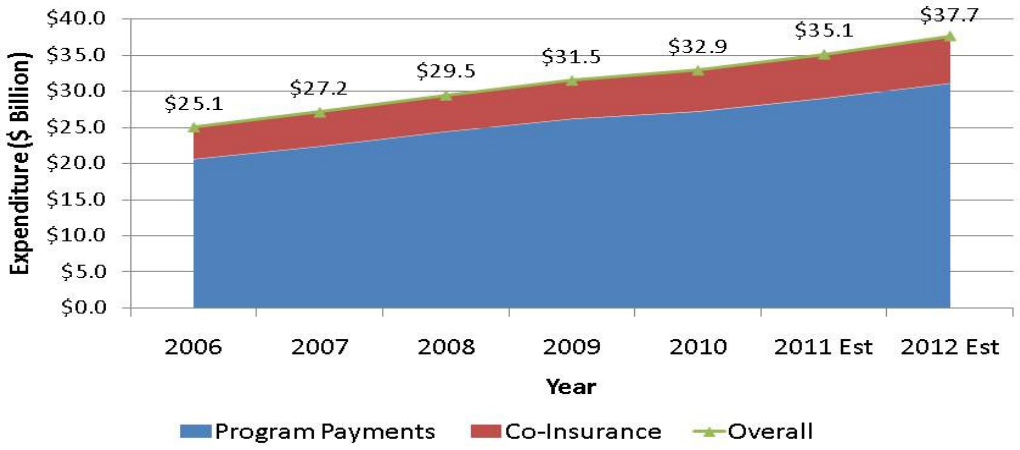
As noted above, AHCA has serious reservations about the accuracy and magnitude of the proposed recalibration of the parity adjustment to the SNF PPS RUG system. Analysis of data from CMS and the SNF sector suggest that the proposed cut is excessive. AHCA analysis of CMS Office of the Actuary data does not show a dramatic change in Medicare SNF expenditures as a result of the implementation of RUG-IV. Similarly, data from a joint survey of nursing facility operators by AHCA and the Alliance for Quality Nursing Home Care (Alliance), as well

as data from LTC Trend Tracker – AHCA's performance and quality improvement tool – also indicate that CMS is overestimating the increase in payments.

AHCA analysis of Medicare patients in SNFs and Medicaid patients in nursing facilities (NFs) as reported by a number of states show a significant decline in patient acuity levels as measured using the Minimum Data Set 3.0 (MDS 3.0) crosswalk to RUG-III. AHCA believes that the observed decline in "measured" patient acuity is likely due to an inherent issue with MDS 3.0 and the crosswalk to RUG-III methodology.

The unexplained decline in patient acuity on October 1, 2011 is contrary to historical trends, daily experience, and conventional wisdom. Even so, the reason for this observed decline in "measured" acuity remains unclear. Irrespective of the reason for the decline, AHCA believes that simulated payments by CMS under RUG-III using MDS 3.0 data result in CMS underestimating payment under the previous RUG system and as a result overestimate the magnitude of the parity adjustment recalibration.

Figure 1: SNF Baseline Expenditures Over Time



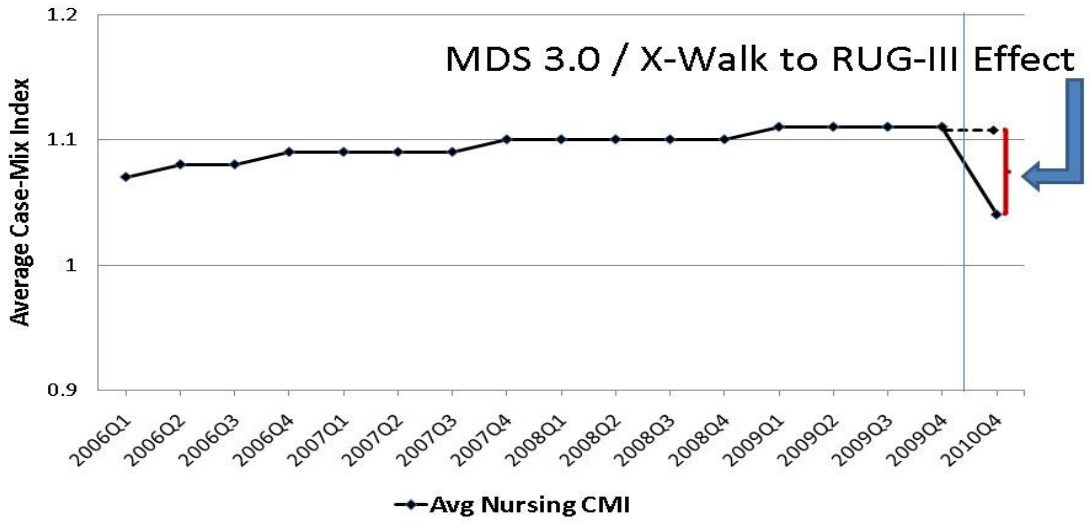
Source: AHCA analysis of unpublished CMS Office of the Actuary data, Medicare Trustees Report, May 2011.

Table 1: Unexplained Decline in "Measured" Acuity (Preliminary Evidence From States)

State	Average Case Mix							
	All Patients				Medicaid			
	3rd Quarter CY 2010	4th Quarter CY 2010	Difference	Percent Difference	3rd Quarter CY 2010	4th Quarter CY 2010	Difference	Percent Difference
Georgia	1.3887	1.3491	-0.0396	-2.85%	N/A	N/A	N/A	N/A
Idaho	1.1667	1.1399	-0.0269	-2.30%	1.0847	1.0523	-0.0325	-2.99%
Indiana	1.2575	1.2609	0.0034	0.27%	1.1528	1.1607	0.0079	0.69%
Iowa	0.9924	0.9617	-0.0307	-3.10%	0.9471	0.9252	-0.0219	-2.31%
Kentucky	1.2240	1.1958	-0.0282	-2.30%	1.1882	1.1582	-0.0300	-2.52%
North Carolina	1.1394	1.1161	-0.0232	-2.04%	N/A	N/A	N/A	N/A
Ohio	2.0815	2.0361	-0.0454	-2.18%	1.9639	1.9124	-0.0515	-2.62%
Virginia	1.1658	1.1345	-0.0313	-2.68%	1.0480	1.0334	-0.0146	-1.39%

Source: AHCA Research Department analysis of quarterly state RUG-III distribution data provided by state Medicaid agencies

Figure 2: Unexplained Decline in "Measured" Acuity (Average Unadjusted Nursing CMIs Under RUG-III)



Source: AHCA Research Department using CMS SNF PPS 100% LDS SAF data (2006-2009) and FY2011 CMS SNF PPS NPRM supplemental data (Distribution of Part A days by RUG-IV group: FY2011Q1)

IV. Proposed SNF PPS RUG Changes and Budget Neutrality

- ***CMS should phase-in changes to the SNF PPS RUG system for FY 2012 in a budget neutral manner***

The redesign of the RUG-IV system was multi dimensional. The parity adjustment that sought to maintain budget neutrality under the RUG-III and RUG-IV SNF PPS systems reflected numerous changes that affected the design and structure of and the incentives under the new system. With MDS 3.0 and RUG-IV, resident characteristics were computed and valued differently, payments associated with regrouped resident classifications were updated, and changes made to program policies introduced.

With this proposed rule for FY 2012, CMS again introduces numerous changes to the design and structure of the RUG system that affect incentives under RUG-IV, including allocation of group therapy minutes, assessment reference date changes, new assessments, and other changes. In proposing changes to the design of the RUG-IV system for FY 2012, CMS failed to incorporate any adjustments to the SNF PPS that would ensure budget neutrality between the existing SNF PPS and a revised RUG-IV SNF PPS for FY 2012. CMS should reevaluate the impact of the agency's proposed changes for FY 2012, including those changes associated with its calculation for the recalibration of the parity adjustment. Given the difficulty in accurately estimating the impact such complex changes to the SNF PPS will have, CMS should phase-in implementation of the parity adjustment recalibration.

V. Budget Neutrality Phase-In: Proposed Implementation

As noted above, numerous issues with the recalibration of the parity adjustment portion of the CMS FY 2012 SNF PPS proposed rule are concerning. AHCA is particularly troubled by the lack of expenditure data supporting CMS' contention about the magnitude of the increase in spending, data from State Medicaid systems and CMS that show an unsupportable reduction in measured acuity of SNF/NF residents after the implementation of MDS 3.0, and the agency's failure to take into account proposed changes to the SNF PPS that will alter the design, structure, and incentives of the RUG-IV system. Taken together, these issues, coupled with issues related to small sample sizes, utilization seasonality, and various MDS 3.0 transition related technical issues as well as CMS policies that will increase nursing and therapy related costs, demonstrate that CMS is overestimating the magnitude of the proposed recalibration of the parity adjustment, particularly when CMS has not taken into account in the recalibration numerous changes to the SNF PPS RUG system for this proposed rule.

Fortunately, there is a solution to this that does not require us to make an educated guess. This solution assures budget neutrality from October 1, 2011 forward, assures that we will ultimately get to the right number, and prevents an unmanageable jolt to the sector.

AHCA proposes that the agency consider:

- Reducing SNF PPS rates for FY 2012 by up to 3.0 percent plus the productivity adjusted market basket update;
- Further reducing rates for FY 2013 and subsequent years, if necessary, up to 3.0 percent plus the productivity adjusted market basket update until budget neutrality is achieved.;
- In determining budget neutrality, CMS should evaluate and include the impact of the various changes to the SNF PPS RUG system described in the FY 2012 proposed rule (e.g. changes to assessment reference date periods and grace days, allocation of group therapy minutes, implementation of the change of therapy (COT) other Medicare required assessments (OMRAs), introduction of the end of therapy – resumption (EOT-R) OMRA, changes to the EOT OMRA, etc.) - i.e. RUG-IV version 2; and
- Prospectively recover non-budget neutral overpayments should the phase-in of the budget neutrality adjustment results in overpayments in FY 2012 and beyond.

AHCA believes that the proposal outlined above achieves budget neutrality; allows the long term and post-acute care sector to absorb phased-in reductions while maintaining quality care for our patients and residents; and avoids unduly impacting our nation's economic recovery.

AHCA and CMS share the same goal – ensuring Medicare and Medicaid beneficiaries have access to quality nursing and rehabilitation services while maintaining fair, appropriate, and stable funding. AHCA also welcomes the opportunity to work with CMS on this proposed rule, and supports a budget neutrality adjustment that prospectively reflects the complete changes from RUG-III through a revised RUG-IV system for FY 2012.

VI. New STRIVE Study Needed To Update Therapy Weights

- ***CMS should undertake a STRIVE-like project to update therapy weights to reflect how therapy services are delivered after all RUG-IV related changes have been implemented***

Dramatic changes have occurred in the delivery of therapy services under the current RUG-IV SNF PPS and the proposed, revised RUG-IV system for FY 2012. The changes are so substantial that STRIVE therapy weights no longer reflect the way that therapy services are delivered in SNFs. Such shift in the delivery of therapy services, along with inadequacies in the collection of STRIVE therapy data, and the manipulations (*i.e.,* distortions) introduced to make the therapy weights work, are indicators that a new STRIVE study should be undertaken to accurately and sufficiently collect the data required to compute therapy weights reflective of how therapy services are delivered in SNFs. The cut-points for rehabilitation RUG categorization have not been reviewed, nor updated, since the SNF PPS RUG system was established. CMS should reexamine and update the rehabilitation RUG cut-points to better reflect new research on improving functional outcomes, changes in resident acuity and the delivery of therapy services, and SNF PPS incentives. CMS also should begin planning for a new STRIVE-like study that can begin in a year or two, once providers have adjusted to all of the RUG-IV-related changes, including proposed changes for FY 2012.

VII. Applying the Parity Adjustment for Budget Neutrality without Distorting SNF Rates

- ***CMS should apply parity adjustments for budget neutrality in a way that does not distort SNF payment rates***

As noted previously, AHCA is supportive of CMS' efforts to implement RUG-IV in a budget neutral manner, and believes that CMS should implement proposed changes for FY 2012 in a budget neutral manner as well. AHCA also appreciates CMS' intent to implement RUG-IV in a way that would "allocate payments more accurately based on current medical practice and updated staff resource data obtained during the STRIVE study, and not to decrease or increase overall expenditures" (74 *Federal Register*, 22237). Unfortunately, the current methodology for allocation of the parity adjustment and the proposed reallocation of the parity adjustment methodology do not promote rate accuracy, but rather distort payment rates.

Currently, CMS applies the parity adjustment as a fixed percentage increase to the nursing weight of each resource utilization group, which skews and distorts RUG-IV payment rates. Ideally, CMS would apply a fixed percentage parity adjustment increase to all four of the components of the RUG-IV payment system to avoid distorting payment rates. Given current limitations, AHCA proposes an alternative methodology, which would apply a budget neutral variable percentage increase to the nursing component across all RUG categories rather than a fixed percentage increase as is CMS' current practice for achieving aggregate budget neutrality. This alternative approach is easily implemented and would not skew or distort RUG-IV payment rates (a more detailed description follows).

VIII. Group Therapy

- ***Adjustments to group therapy under the SNF PPS RUG system should recognize and fairly reimburse for higher group therapy related costs***

Group therapy is critical to improving functional outcomes of SNF patients. Benefits to patients include functional improvements, greater psychological and social awareness, social interaction, and patient motivation. Group therapy also requires great skill and planning, and is more expensive to offer. Group therapy requires individual evaluation needs and documentation requirements for each patient, as well as increased communication, coordination and planning needed for each group session. Adjustments to group therapy under the SNF PPS RUG system should recognize the more complex aspects of providing group therapy and fairly reimburse for these additional expenses.

- ***CMS should examine alternatives that address overreaching incentives in the SNF PPS for providing group therapy, without negatively impacting beneficiary functional outcomes, nor penalizing SNFs that provide group therapy services.***

In order to reduce the incentive to over-utilize group therapy, CMS "believes" that group therapy is optimal when provided to four patients. So, the agency's proposed allocationof group therapy minutes is based on a 4-person group, irrespective of the actual number of patients in the group. CMS' premise is faulty, as there are numerous instances when a 2-person or 3-person group is effective, and in some cases, superior to a 4-person group. Under some circumstances, conducting therapy for a 4-person group could pose serious patient safety risks. The appropriate usage of group therapy should be determined by the treating therapist, who can best assess the preferred or optimal size of the group based on the needs of the patients, and not an arbitrary, unsubstantiated policy.

The proposed allocation of therapy minutes based on a 4-person group establishes perverse incentives. It fails to recognize increased costs associated with providing group therapy in 4-person groups. This arbitrary allocation also inappropriately and significantly limits incentives for providing therapy in 2- and 3- person groups, despite the evidence that such therapy is beneficial, and often preferred to 4-person group therapy. CMS should examine alternatives that address the over incentive in the payment system to provide group therapy, without negatively impacting functional outcomes for beneficiaries, and penalizing SNFs that provide group therapy services.

IX. Options for Adjusting Group Therapy

- ***CMS should examine changes to the current cap on group therapy minutes to reduce the incentive to over-utilize group therapy***

Currently, group therapy services are limited to a maximum of 25 percent of total therapy minutes by discipline. This limitation exists to ensure that group therapy is not a substitute for individual therapy, but rather an adjunct to it. If there are concerns about possible over-utilization of group therapy services, CMS should examine the appropriateness of the present cap on group therapy minutes. CMS could adjust the cap to a more appropriate level keeping in mind that the cap represents the high-end limit of allowed group therapy, and not an average or target for allowed group therapy utilization. Adjusting the cap offers an administratively simple method to address the alleged increase in group therapy minutes.

- ***If CMS decides to allocate group therapy minutes, CMS should allocate group therapy minutes based on actual group size and recognize and reimburse for the increased cost of providing group therapy services***

If CMS proceeds with allocating group therapy minutes, CMS should allocate group therapy minutes based on actual group size. Doing so would not unduly penalize SNFs for providing therapy services in 2- and 3- person groups, nor would it create inappropriate incentives for providing 4-person group therapy. Such an approach does not recognize the additional burdens and costs associated with the provision of group services, however, nor the difficulty providers and therapists would have in tracking the number of people in a group at all times and accurately counting minutes when patients are dropping in and dropping out throughout a session. Should CMS wish to adopt this sort of policy, providers may be able to use technological advances that

can better track patient participation in group therapy sessions, albeit with increased provider burden and cost, which CMS should recognize. In addition, if CMS proceeds with the allocation of group therapy minutes, it should modify the SNF PPS to eliminate or mitigate the disincentive for group therapy it will have introduced, and explore some means for recognizing and reimbursing providers and therapists for the increased burden and cost associated with providing group therapy services.

- ***As an interim step, if CMS decides to allocate group therapy minutes, CMS should adjust group therapy minutes based on average group size***

In the interim, CMS should consider adjusting group therapy minutes based on the current average size of a therapy group, rather than an arbitrary cap that is based on the maximum number of patients established by Medicare payment policy. This option would pay providers "fairly" for therapy provided to 3-person groups, penalizes providers for providing therapy in 2-person groups, and encourages providers to provide therapy in 4-person groups and reflects the additional burden and costs associated with the provision of therapy services to more than one person at a time. Also this less administratively burdensome option, would not require providers to track minutes of group therapy based on group size. We encourage CMS to undertake research to determine average group size so as to be able to appropriately and fairly adjust group therapy minutes in the calculation of total minutes for rehabilitation RUG assignment.

- ***Any adjustments to group therapy in the SNF PPS RUG system should be implemented in a budget neutral manner.***

While AHCA would prefer any adjustments to group therapy maintain flexibility and "fairly" reimburse for therapy services without unduly increasing the cost of providing therapy services, we are more concerned that any adjustments to group therapy be implemented in a budget neutral manner. Changes to group therapy, much like the replacement of Section T and the allocation of concurrent therapy minutes under RUG-IV, are intrinsic to the SNF PPS. These and other proposed changes will impact case-mix, the integrity of the payment system, and the stability and financial viability of the SNF sector. Again, any adjustments to group therapy should be implemented in a budget neutral manner.

X. Change of Therapy (COT) Other Medicare Required Assessments (OMRAs)

In the proposed rule, CMS introduces a new assessment, the Change of Therapy Other Medicare Required Assessment (COT OMRA). Under CMS' proposal, SNFs would need to evaluate the amount of therapy delivered and the level of therapy for rehab RUG classification on a weekly basis (i.e. every 7 days). A COT OMRA would be required whenever the amount of therapy provided to a Medicare beneficiary changed to such a degree that that the patient would not remain classified into the RUG-IV group on the most recent Medicare assessment. CMS is proposing to introduce the COT OMRA because of information that "therapy services recorded on a given PPS assessment did not provide an accurate account of the therapy provided to a given resident outside the observation period used for the most recent assignment." CMS further

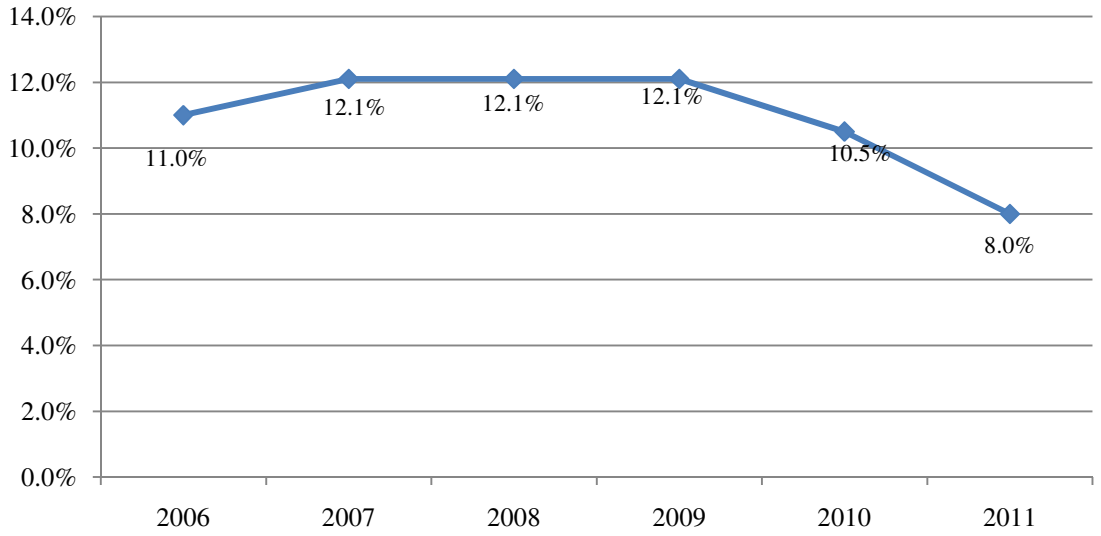
notes that "in some cases, changes in therapy utilization levels may even be unrelated to the patient's clinical condition but may be caused by staffing constraints or facility practices."

AHCA agrees that CMS should only pay for those therapy services provided to Medicare beneficiaries. Given the goals of a prospective payment system, and the design of the SNF PPS, including how therapy is paid, we understand CMS' concerns.

- ***CMS should reexamine whether existing or other less-burdensome alternative options are available and sufficient to address perceived issues with facility practices in the provision of therapy services***

AHCA understands CMS' concerns regarding therapy services outlined in its proposed rule, although how large an issue increased use of therapy services is for the Medicare program is unclear. If concerns about SNF or therapy provider practices were widespread, we would expect that the Recovery Audit Contractors (RACs), Medicare Audit Contractors (MACs), and CMS surveyors (See Figure 3) would be scrutinizing provider behavior very closely. Yet, in reviewing survey citations over time, and RAC and MAC SNF focus issues, we find no clear indication that current behavior is suspect, much less that it is a widespread issue that needs addressing through payment policy and increases provider burdens.

Figure 3: Citations for Accuracy of Assessment (Tag F278)



Source: CMS OSCAR/CASPER Data, Nursing Facility Standard Health Surveys, June of each year
American Health Care Association - Research Department

The burden on providers for monitoring for and filing Change of Therapy (COT) Other Medicare Required Assessments (OMRAs) is significant. CMS estimates the extra reporting, coding and transmission requirements for COT OMRAs will require about one million hours of staff time at a cost of over $32 million annually. Yet, the staff time and cost estimates offered by CMS do not include the time and cost involved in collecting and evaluating the information necessary to determine whether a COT OMRA is required. If one assumes three COT OMRA-related evaluations are required during a 30-day stay, the cost is likely to exceed $100 million annually. These significant staff resource and cost issues are further compounded when factoring in the opportunity costs related to the COT OMRAs.

With overall SNF margins hovering near one percent, increased costs for proposed changes to group therapy, assessment reference dates (ARDs) and now COT OMRAs, it will be challenging for SNF providers to absorb these additional increases in operating costs. AHCA worries that the diversion of nursing and other direct care staff resources away from patient care in order to do paperwork will cause quality to suffer. We encourage CMS to evaluate alternatives to the COT OMRA that would not favor the completion of unnecessary paperwork over meeting the nursing and rehabilitative needs of the Medicare beneficiaries that we serve. Since the proposed introduction of the COT OMRA will significantly add to the burden of MDS Coordinators and spur on the need for new evaluations on the part of all therapists, we call on CMS to reexamine whether existing or other less-burdensome alternative options are available and sufficient to address perceived issues with facility practices in the provision of therapy services.

- ***If CMS proceeds with the COT OMRA, CMS should allow flexibility in the choice of the assessment reference date of the COT OMRA***

Instead of addressing CMS' concerns about inappropriate provider and therapy company practices, the COT OMRA, as currently proposed, would significantly penalize SNFs for one-time, resident-specific issues that are outside of the provider's control. In implementing the COT OMRA, CMS should allow SNFs to have the flexibility to make up therapy that was missed due to patient refusal, transient issues, or planned breaks in care.

In order to distinguish between inappropriate provider practices and one-time, resident-specific issues, we ask CMS to modify the COT OMRA to allow for flexibility in the choice of assessment reference date (ARD) or allow for grace days at the beginning and end of the 7-day COT OMRA ARD window as is the case with other Medicare required assessments. Flexibility in the choice of ARD will prevent CMS payment policy from penalizing SNFs for one-time, resident-specific issues that are beyond the provider's control or are in the best interest of the resident, while addressing CMS' concerns about inappropriate practices.

- ***If CMS proceeds with the COT OMRA, CMS should not require a COT OMRA during the first 30 days of a patient's SNF stay.***

CMS proposes that a facility evaluate and file a COT OMRA every seven days after a Medicare-required assessment or end of therapy-resumption (EOT-R) OMRA. The first 30 days of a rehab patient's stay in a SNF is marked by frequent observation, intensive therapy intervention, and numerous required Medicare assessments. During the first 30-days of a SNF completes three

assessments (e.g. the 5-day admission, the 14-day, and the 30-day required Medicare assessments). In a COT OMRA environment, a SNF would be required to evaluate and if necessary complete up to an additional three COT OMRAs, two of which might be required within a day or two of the required Medicare assessment. Evaluation and completion of COT OMRAs under these circumstances is excessive and duplicative, particularly given that there does not appear to be a widespread issue, and which is or could be addressed by other means. If there is no other less burdensome option available to address the provider practice issue, CMS should not require that a COT OMRA be completed during the first 30 days of a patient's SNF stay.

XI. End-of-Therapy OMRAs

- ***CMS should expand the EOT OMRA ARD window to four calendar days***

With the implementation of RUG-IV, CMS introduced the End-of-Therapy OMRA into the SNF PPS. An EOT OMRA was to be completed 1 to 3 days after the discontinuation of all therapies. With the FY 2012 SNF PPS proposed rule, CMS clarified that an EOT OMRA must be completed within 1 to 3 days after the discontinuation of all therapy services for three days, regardless of the reason for the discontinuation and irrespective of whether the facility provides therapy services 5-days or 7-days per week. While CMS' proposal goes a ways toward resolving issues with the selection of the ARD for an EOT OMRA, it does not take into consideration a fundamental problem with the EOT OMRA – namely that many SNFs provide therapy 5 days per week and SNF residents occasionally miss a day of therapy for a variety of reasons including holidays, patient illness, Doctor's appointments, or other scheduling conflicts.

A simple modification to the EOT ARD window could easily resolve this issue. Expanding the EOT OMRA assessment window to four calendar days rather than the arbitrary three day window would resolve the issue with breaks in therapy involving weekends and holidays. Feedback from member organizations of AHCA and the National Association for the Support of Long-Term Care (NASL) suggests that about 65 percent of the EOT OMRAs were prompted by one-time patient issues that occurred on a Friday or Monday, primarily in SNFs that provide therapy 5-days per week. Extension of the EOT OMRA ARD to up to four calendar days would eliminate filing numerous, unnecessary EOT OMRAs and EOT-R OMRAs and the need for additional therapist EOT-R OMRA related evaluations – the minutes for which are not reportable or reimbursable on the MDS. AHCA urges CMS to expand the EOT OMRA ARD window to four calendar days.

XII. Provider Burden: Care Delivery Versus Documentation

- ***CMS should evaluate proposed changes to MDS 3.0 and the SNF PPS as well as the overall burden on providers participating in the Medicare and Medicaid programs, and identify requirements and solutions to operational and policy goals that minimize complexities, streamline processes, and minimize documentation and other administrative burdens***

One of the more challenging aspects of the proposed rule relates to increased documentation and administrative burdens. Implementation of MDS 3.0 and RUG-IV has dramatically increased administrative burdens and provider costs. Based on data from PointRight, SNFs completed 2.42 MDS 2.0 assessments per Medicare stay under the old system. Now, SNFs complete an average of 3.15 MDS 3.0 assessments per Medicare stay under the new system, a 30% increase in the number of assessments. This translates into well over a million additional MDS assessments and hundreds of million of dollars in additional costs. Similarly, changes in the SNF PPS led to a dramatic increase in the amount of individual therapy that was provided by SNFs. These changes also increased costs by hundreds of millions of dollars. Proposed changes to the SNF PPS RUG system this year will also dramatically increase costs in FY 2012. Providers do not recoup these cost increase through market basket adjustments to the SNF PPS. The changes to MDS 3.0 and RUG IV coupled with the additional proposed changes have and will further result in provider's becoming inefficient and less productive. Furthermore, assessment changes and associated costs go beyond Medicare. The paperwork burden has been increased for all payors, not just Medicare.

Providers need relief from ever increasing documentation and administrative requirements. AHCA is concerned that the current volume of documentation will distract SNFs from their primary mission – caring for frail, elderly, and disabled Medicare beneficiaries. In addition, costs of these unfunded mandates are rapidly increasing. This is all the more challenging in an environment where states and other payors are looking to further reduce low and declining reimbursement rates. AHCA urges CMS to take action and evaluate proposed changes to MDS 3.0 and the SNF PPS as well as the overall burden on providers participating in the Medicare and Medicaid programs, and identify requirements and solutions to operational and policy goals that minimize complexities, streamline processes, and minimize documentation and other administrative burdens.

XIII. Disclosure

- ***CMS should minimize the burden of the additional disclosure of ownership and additional parties information required under the ACA***

AHCA first responds to CMS' assertion that these proposed expansive, and in many cases impractical, requirements for information disclosure are needed because owners of long term care facilities have lacked transparency in ownership disclosure. AHCA fully supports the goal of providing information to residents and their facilities in order for them to make informed decisions about nursing facility care, and furnishing relevant information about facility ownership and organizational structure to CMS. AHCA, however, contends that that there is no evidence to support that there have been efforts by long term care facilities to "shield" owners from responsibility for the operation of facilities, to protect themselves from liability or to reduce necessary resident care and services. AHCA also asserts there is no evidence to support that the quality of nursing home care suffers when a facility is owned by a private equity firm or an investment company.

AHCA renews its recommendation that CMS convene stakeholders in the development of a standardized form, alternatives for disclosure and the key definitions and mechanics for completion. Clarification needs to be made by CMS on whether the CMS-855A form, or some version of that form, (disclosure form) will be the form that will be used by Medicaid programs for NFs. AHCA also requests clarification on whether the disclosure form will satisfy the disclosure requirements under Section 6101 of the ACA.

In regards to the completion of the disclosure form, AHCA recommends simplifying the definition of the additional disclosable party to include the term "day-to-day operations of the facility". This term would provide clarification on those parties for which information is required to be submitted. In addition, the definition of the term "managing employee" needs to be clarified to include those individuals that are typically managing the facility, the Administrator or Executive Director. In the case of a corporate office situation, the term "parent company or home office company" needs to be included in the definition.

It is reasonable for a facility to disclose its own organizational structure, but obligating facilities to disclose information about organizations that have no control over the operations of the facility pose difficult implementation issues and ongoing administrative burden and should not be required.

AHCA strongly supports the CMS proposal to require updating the disclosure form only upon revalidation consistent with the requirements of 42 CFR 424.15, and agrees with CMS that 30 days is far too short a period to report changes in the extensive amount of information that must be provided on the disclosure form. We encourage CMS to advocate this position with state Medicaid programs as well.

Conclusion

Investing in efficient, effective, quality skilled nursing, rehabilitative and chronic care will yield improved quality of life and chronic condition management after an acute event for Medicare beneficiaries who receive care. Our investment in long term and post-acute care also will benefit the Medicare program in terms of lowered program costs over time.

AHCA's detailed analysis appears below and we welcome any questions that CMS might have regarding our research and the findings we include in these comments. We also would be pleased to answer any questions about our enclosed recommendations for the FY 2012 SNF PPS rule.

Table of Contents

Summary of AHCA Recommendations

AHCA Recommendation on Budget Neutrality and the SNF PPS RUG System:

- *CMS should implement changes to the SNF PPS RUG system in a budget neutral manner;*
- *CMS should phase-in budget neutrality adjustments to the SNF PPS RUG system;*
- *CMS should be consistent in its application of its own long established phase-in policy and thus phase-in any parity adjustments to the SNF PPS RUG system;*
- *CMS should investigate and resolve data and methodology issues with the agency's calculation of the parity adjustment and re-estimate the recalibration of the parity adjustment for budget neutrality; and*
- *CMS should phase-in changes to the SNF PPS RUG system for FY 2012 in a budget neutral manner.*

AHCA Recommendations on Application of Parity Adjustment for Budget Neutrality:

- *CMS should apply parity adjustments for budget neutrality in a way that does not distort SNF payment rates.*

AHCA Recommendation on Updating Therapy Weights to Reflect Delivery of Therapy Services Under RUG-IV:

- *CMS should undertake a STRIVE-like project to update therapy weights to reflect how therapy services are delivered after all RUG-IV related changes have been implemented;*
- *As part of the new project, CMS should collect information on therapy utilization and delivery to update the therapy weights under the RUG-IV system; and*
- *As part of the new project, CMS should examine and refine the categories for rehabilitation RUG assignment.*

AHCA Recommendations on a Cumulative Market Basket Forecast Error Correction:

- *CMS should adhere to the precedent followed in its 2003 actions, which underscored the critical importance of accuracy in payment decisions, by acting decisively when the cumulative impact of market basket forecasting errors erode SNF payment rates by modifying the agency's threshold policy to apply a cumulative correction for market basket forecasting errors when the 0.5% threshold is reached on a cumulative basis.*

AHCA Recommendations on Non-Therapy Ancillary Services (NTAS):

- *AHCA is broadly supportive of CMS' efforts to improve reimbursement for NTAS in the SNF PPS;*
- *AHCA is broadly supportive of CMS' efforts to develop a separate NTAS component and index or reasonable NTAS end-split in the SNF PPS RUG system that:*
    - *Uses information from available SNF administrative data sources;*
    - *Uses variables that are highly predictive of resource use, clinically sensible, and sensitive to patient NTAS utilization;*
    - *Appropriately incentivizes providers;*
    - *Collects additional information from SNF administrative data sources after due consideration and evaluation of the additional information on developing and allocating NTAS payments and provider costs and administrative burdens;*
    - *Includes a base payment for every patient day tht covers the cost of routine NTAS;*
    - *Includes a tiered payment to reflect and better target NTAS payments to patients with high non-routine NTAS costs;*
- *CMS should examine and design the NTAS component such that it reflects and accurately pays for NTAS services particularly those included under consolidated billing;*
- *CMS should examine and design the NTAS component so that it captures and accurately pays for broad classes of high cost drugs or pays based on an annually updated list of high cost drugs administered by the Secretary;*
- *CMS should continue to examine and explore the development of a NTAS component using existing data sources such as MDS 2.0, but the final analysis and design of the NTAS component before implementation should be based on currently used administrative data (i.e. MDS 3.0);*
- *CMS should explore the development of an outlier policy for NTAS including a cost pass through for high cost drugs and equipment; and*
- *CMS should involve stakeholders such as AHCA early in the process to inform the research and provide technical expertise on the development of a modification to the SNF PPS that better aligns NTAS costs with payments.*

AHCA Recommendations on Wage Index Reform:

- *AHCA opposes the development and imposition of a SNF area wage index that still only reflects the cost or price of labor in the hospital setting, which could again lead to the establishment of a new system with reclassification adjustments. Any revisions to the area wage index methodology should be appropriately applicable to both hospitals and LTPAC settings;*
- *AHCA encourages CMS to develop an improved area wage index methodology using data that reflects the price of labor rather than the cost of labor and that appropriately adjusts Medicare payments for geographic labor price and thereby resolves the boundary effect issue for hospitals and providers across the health care spectrum;*
- *Any reform to the design, development, and implementation of the hospital wage index must be eventually applied to SNFs and other LTPAC settings;*

- *AHCA supports the development of an improved wage index methodology that would rely on more appropriate data, which would eliminate the need for reclassification, and provide a mechanism for appropriately adjusting payment systems for differences in the price of labor in local markets;*
- *AHCA is broadly supportive of using U.S. Bureau of Labor Statistics (BLS)-type data reflecting the price of labor for all health care sector employers in the development of a wage index for hospitals and for LTPAC settings, as recommended by the IOM;*
- *AHCA is supportive of efforts and appropriations to have CMS work with BLS and collect BLS-type survey data from all Medicare-and/or Medicaid-certified hospital and LTPAC providers on an annual basis;*
- *AHCA supports the collection of information on commuting patters for all LTPAC settings, and not just for hospital employees, in order to make adjustments to the wage index methodology to resolve the boundary effect issue; and*
- *CMS should phase-in any new wage index methodology, particularly one that resolves the boundary effect issue, to allow providers the opportunity to adjust their labor costs over time.*

AHCA Recommendations on a SNF Wage Index Adjustment:

- *CMS should review its SNF wage index adjustment methodology, adjust its methodology as necessary to ensure that it is applied correctly as per statute in a manner that does not result in aggregate payments that are greater than or less than would otherwise be made in the absence of the wage adjustment, and make any necessary adjustments to make up for past wage index related underpayments.*

AHCA Recommendations on the Allocation of Group Therapy Minutes:

- *Adjustments to group therapy under the SNF PPS RUG system should recognize and fairly reimburse for higher group therapy related costs;*
- *CMS should examine alternatives that address overreaching incentives in the SNF PPS for providing group therapy, without negatively impacting beneficiary functional outcomes, nor penalizing SNFs that provide group therapy services;*
- *CMS should examine changes to the current cap on group therapy minutes to reduce the incentive to over-utilize group therapy;*
- *If CMS decides to allocate group therapy minutes, CMS should allocate group therapy minutes based on actual group size and recognize and reimburse for the increased cost of providing group therapy services;*
- *As an interim step, if CMS decides to allocate group therapy minutes, CMS should adjust group therapy minutes based on average group size; and*
- *Any adjustments to group therapy in the SNF PPS RUG system should be implemented in a budget neutral manner.*

AHCA Recommendations on Changes to Group Therapy Documentation Requirements:

- *CMS should apply therapy documentation requirements to skilled nursing facilities using only SNF laws and regulations.*

AHCA Recommendations on Changes to the Assessment Reference Date Window for End-of-Therapy (EOT) OMRAs:

- *CMS should expand the EOT OMRA ARD window to four calendar days.*

AHCA Recommendations on the Introduction and Implementation of Change of Therapy (COT) OMRAs:

- *CMS should reexamine whether existing or other less-burdensome alternative options are available and sufficient to address perceived issues with facility practices in the provision of therapy services;*
- *If CMS proceeds with the COT OMRA, CMS should allow flexibility in the choice of the assessment reference date of the COT OMRA;*
- *If CMS proceeds with the COT OMRA, CMS should not require a COT OMRA during the first 30 days of a patient's SNF stay; and*
- *Any implementation of the COT OMRA, as well as SNF PPS RUG system changes related to EOT OMRAs, EOT-R OMRAs, ARD windows and grace days, student supervision, among others in the proposed rule should be undertaken in a budget neutral manner.*

AHCA Recommendations on Changes to ARD Windows and Grace Days:

- *CMS should conduct an analysis before imposing the proposed assessment schedule changes.*

AHCA Recommendations on Therapy Student Supervision:

- *CMS should eliminate the line-of-sight requirement for a supervising therapist in situations where a student therapist is prepared to provide rehabilitation services independently without direct therapist supervision;*
- *CMS should allow the time associated with rehabilitation services provided by a prepared independently operating student therapist to be counted fully as skilled therapy minutes on the MDS; and*
- *CMS should allow therapist time to be counted fully as skilled therapy minutes on the MDS when not supervising a prepared and independently operating student therapist, whether the student therapist is in or not in the line-of-sight of the therapist.*

AHCA Recommendations on Consolidated Billing:

- *AHCA requests that CMS exclude from the Part A bundle high cost and low probability cytotoxic chemotherapy drugs recommended for exclusion by AHCA;*
- *We ask CMS to support the highest quality cancer treatment for Medicare beneficiaries; exclude high cost and low probability drugs that are used in the treatment of cancer including antineoplastic antiemetics, and supportive medications;*
- *CMS should remove the medical treatment, hyperbaric oxygen therapy, from the SNF Part A bundle; and*
- *CMS should examine current medical practice and modify its policy of permitting certain services to be excluded from the SNF PPS only if provided in a hospital; CMS should permit these same services to be excluded if they are provided suitably and appropriately in sites other than hospitals, chiefly in freestanding clinics.*

AHCA Recommendations On The Development Of A Plan To Implement A Value Based Purchasing Program (VBP)For SNFs:

- *CMS should delay the report to Congress until it can study and incorporate the results of the SNF VBP demonstration;*
- *CMS should identify or develop measures (outcome measures) that reflect the purpose and goals for post acute care that are appropriate for VBP as currently available MDS measures do not capture the major outcomes and goals of post acute care;*
- *CMS Should Consider and Harmonize SNF Current and Future Quality Related Programs and Collaborative Efforts in Designing a SNF VBP Program;*
- *CMS should not move forward with a specific value-based purchasing plan for skilled nursing centers without validated quality measures that reflect data collected under MDS 3.0, and treatment of the survey issues addressed below;*
- *CMS should evaluate and incorporate lessons learned from Medicaid demonstrations that have a VBP component;*
- *CMS should complete its current rehospitalization studies to better delineate criteria for avoidable and non-avoidable rehospitalizations and to develop adequate risk adjusters;*
- *If CMS plans to use structural measures of quality (e.g. staffing) in a VBP program), CMS should develop staffing measure that accounts for the differences in facilities, consider therapist and physicians in the staffing count, and take into account staff experience;*
- *CMS should incorporate customer and employee satisfaction measures; and*
- *Regarding payment, if budget neutrality is prescribed, CMS should consider an approach that does not punish providers and relies on savings from the reduction of rehospitalization.*

AHCA Recommendations on Payment Adjustment for Hospital-Acquired Conditions (HAC):

- *CMS should provide adequate and meaningful consultation with stakeholders from all post-acute settings and to integrate lessons learned from other quality and payment reform efforts;*
- *CMS should evaluate what conditions from the HAC apply to the SNF setting, since not all HACs apply to SNF setting;*
- *CMS should evaluate how data sources for indentifying HAC in SNF are different from the hospital setting;*
- *CMS should define how to attribute HAC to SNF when HAC was the result of care provided prior to admission to SNF;*
- *CMS should evaluate the unintended consequences of extending payment adjustments for HAC on access, cost and quality of care;*
- *CMS should prevent double jeopardy for HAC when a facility is cited and fined by Medicare Survey & Certification program for an HAC related F-tag and the facility also qualifies for payment adjustment due to their HAC rate;*
- *CMS should consider how managed care, private insurance and private pay patients will be included in the calculation of a provider's HAC rate;*
- *In expanding the HAC policy to SNFs, CMS should consider the plethora of programs indicated above in an effort to co-ordinate and perhaps integrate where possible and avoid redundancy and conflict;*
- *CMS should understand that the Medicare SNF PPS payment system does not lend itself to the financial negative adjustment envisioned by a HAC system; and*
- *CMS should crosswalk the Medicare SNF PPS with the hospital DRG system to ensure that an extension of the financial adjustment can be implemented correctly.*

AHCA Recommendations on Documentation and Administrative Burden:

- *CMS should evaluate proposed changes to MDS 3.0 and the SNF PPS as well as the overall burden on providers participating in the Medicare and Medicaid programs, and identify requirements and solutions to operational and policy goals that minimize complexities, streamline processes, and minimize documentation and other administrative burdens*

AHCA Recommendations on Required Disclosure of Ownership and Additional Disclosable Parties Information (Section 6101):

- *CMS should minimize the burden of the additional disclosure of ownership and additional parties' information required under the ACA.*

I. Budget Neutrality and the SNF PPS RUG System

(Comments on Section II.B.2: Parity Adjustment)

AHCA Recommendation on Budget Neutrality and the SNF PPS RUG System:

- *CMS should implement changes to the SNF PPS RUG system in a budget neutral manner;*
- *CMS should phase-in budget neutrality adjustments to the SNF PPS RUG system;*
- *CMS should investigate and resolve data and methodology issues with the agency's calculation of the parity adjustment and re-estimate the recalibration of the parity adjustment for budget neutrality; and*
- *CMS should phase-in changes to the SNF PPS RUG system for FY 2012 in a budget neutral manner*

A. Background

As we have noted in previous comments, the American Health Care Association (AHCA) is supportive of the Centers for Medicare and Medicaid Services' (CMS) goal to implement modifications to the skilled nursing facility prospective payment system (SNF PPS) in a budget neutral manner. Whether it was the transition from RUG-44 to RUG-53 under the old Resource Utilization Group version 3 (RUG-III) system in fiscal year (FY) 2006 or the transition from RUG-III to RUG-IV in FY 2011, AHCA believes that changes to the SNF PPS RUG system should be implemented in a budget neutral manner so as to maintain the stability and financial viability of the SNF sector and ensure that Medicare beneficiaries continue to have access to skilled nursing and therapy services.

For the FY 2010 SNF PPS proposed rule, AHCA commented extensively on numerous issues related to the CMS Staff Time Resource Intensity Verification (STRIVE) study and the implementation of RUG-IV. In our comments, we noted problems with the representativeness of the STRIVE data and expressed concerns about the small sample size and its utilization to calibrate overall payments and budget neutrality. As it turns out, these issues, coupled with unexpected provider response to altered RUG system incentives, has led to a non-budget neutral increase in expenditures under the new RUG-IV system. While we highlighted some of the issues, AHCA is also sympathetic to how difficult it can be to implement changes to the SNF PPS RUG system in a budget neutral manner, particularly when the changes to the PPS radically realign its design, modify its underlying structure, and influence provider incentives.

Similar to our concerns in the FY 2010 SNF PPS proposed rule, AHCA again has grave concerns about the accuracy and magnitude of the proposed CMS recalibration of the parity adjustment, particularly as the agency implements other changes to the SNF PPS RUG system will affect the budget neutrality calculus. As we describe further below, AHCA urges CMS to use a phased approach to the implementation of the recalibration of the parity adjustment to get it "right" and not inadvertently introduce changes that could destabilize the financial viability of the SNF sector during these fiscally challenging times for all.

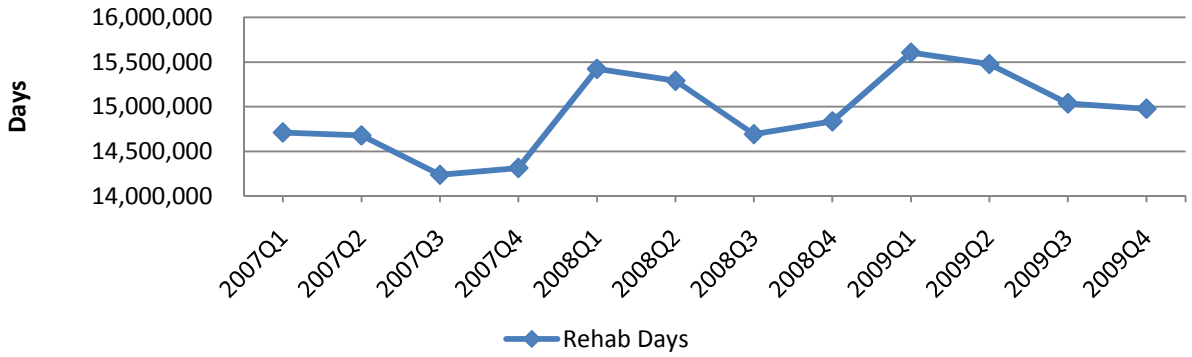
B. Data Issues That Could Skew Budget Neutrality Estimation

In previous years when CMS switched the SNF PPS from one RUG system to another or introduced a recalibration of the parity adjustment between RUG systems, CMS relied on one complete year's worth of data to estimate and help ensure budget neutrality. Basing budget neutrality on one year's worth of data has its advantages and disadvantages. In theory, parity adjustments for budget neutrality should be calculated at the time of the transition to eliminate the influence of acuity, resident and provider factors; all patients in nursing facilities at the time of transition should be used as a control group and evaluated under the old and new RUG system, payments calculated, and parity adjustments for budget neutrality computed and applied. Unfortunately, the patients in SNFs at anyone time of the year are not sufficiently representative of the patients utilizing SNF services through out a given year. Similar issues arise when using one month's, or one quarter's, or one half of a years worth of data. As a result, it is becoming increasingly clear that a full year's worth of data is required to sufficiently reflect SNF utilization and payments, and make parity adjustments for changes in payment systems.

1. Seasonality of Data

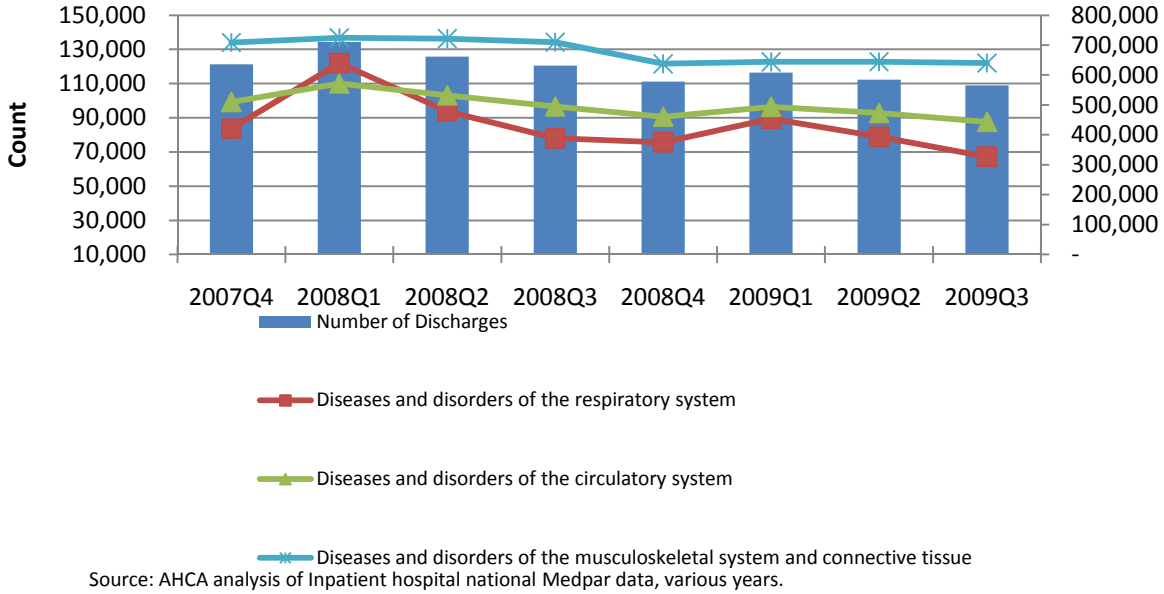
AHCA is concerned that recalibration of parity adjustments for budget neutrality based on data for one quarter or one half of a year is not sufficiently representative of SNF utilization and payments to accurately make appropriate adjustments to being about budget neutrality between payment systems. As show in Figures 1 and 2 there is considerable seasonal variation in utilization of SNF services and the types of patients utilizing SNF services. Seasonal variation also exists in SNF payment rates and SNF expenditures (Figure 3).

Figure 1: Seasonality of SNF Rehabilitation Services



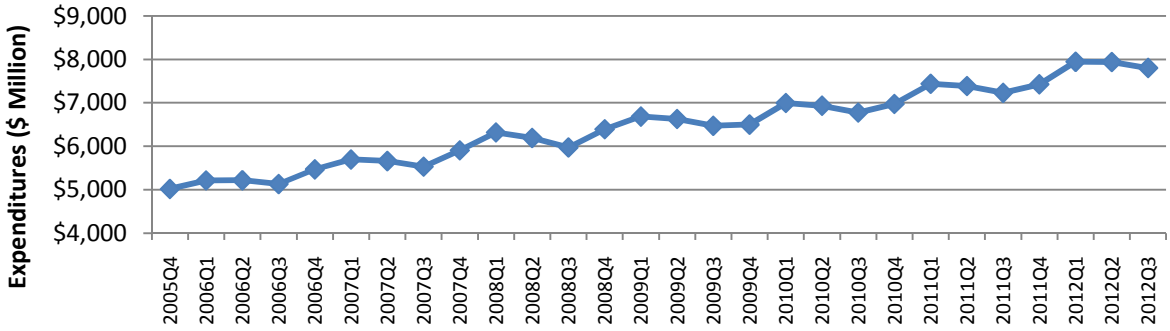
Source: AHCA analysis of CMS 100% SNF LDS claims data, various years.

Figure 2: Seasonality of SNF Patients by Major Diagnostic Category



Source: AHCA analysis of Inpatient hospital national Medpar data, various years.

Figure 3: Seasonality of Medicare SNF Program Payments



Source: AHCA analysis of unpublished CMS OACT data, Medicare Trustees Report, May 2011

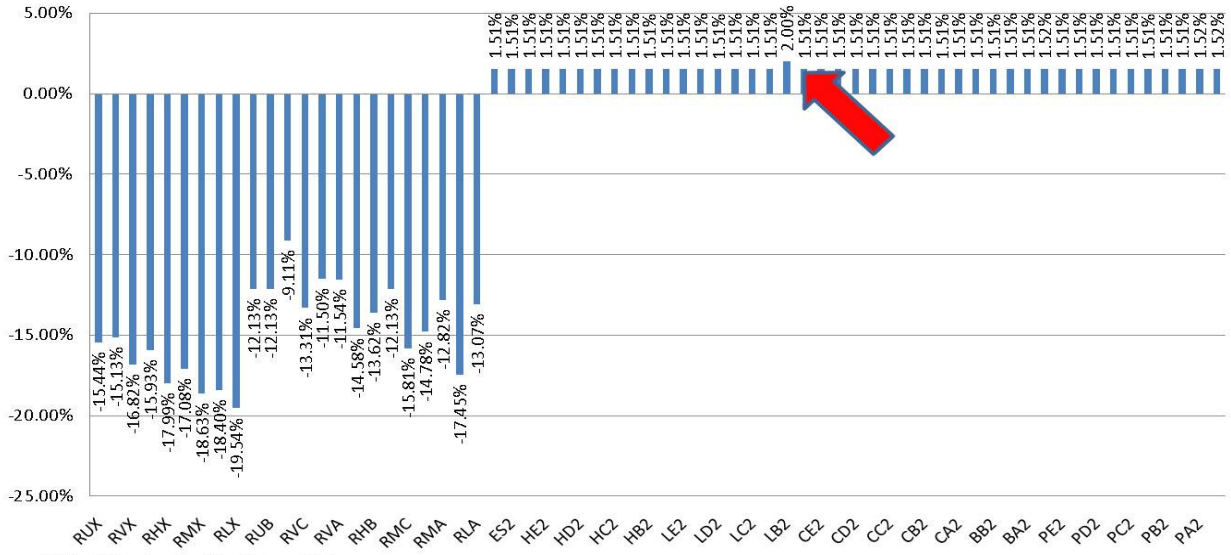
2. Issues with 1st Quarter FY 2011 MDS and Claims Data

AHCA is also concerned with the MDS and the claims data utilized by CMS to determine budget neutrality. In the proposed rule, CMS noted that if constructed a file which linked 920,000 first quarter FY 2011 claims data to the corresponding MDS assessments. With the release of the proposed rule, CMS made available information on the national distribution of Part A days by RUG-III and RUG-IV categories and urban/rural indicator using this data file, and in late June made available information on the distribution of Part A days by RUG-III and RUG-IV categories at the provider level.

AHCA is concerned that the first quarter FY 2011 data may be skewed and of undetermined reliability in accurately representing the services provided by SNFs, computing aggregate payments, and calculating budget neutrality adjustments. A few issues give us pause. First,

MDS data submitted during this period had numerous issues. MDS 3.0 was new to providers and providers have described numerous problems and issues with completing the MDS as they became familiar with the new assessment tool. Second, providers and CMS also had to work out a number of kinks in the data submission system during this period. These included transition related issues (validation reports) that delayed MDS and claim submissions, software vendor MDS validation and submission issues, software vendor claims submission issues, incorrect CMS payment related issues that necessitated reprocessing and adjustment for all SNF PPS claims paid between October 1 and February, etc. Third, a few provider organizations examined the distribution of their Part A days have brought to our attention that the number and distribution of Part A days using the provider level data released by CMS in late June and compared it to their actual paid Medicare Part A days over the same periods. These provider organizations found significant differences between the two data files. In one case, the CMS data showed that they had 65% more days then the facility actually received payment for. It is unclear what effect these numerous data issues could have on the computation of the parity adjustment. Lastly, as Figure 4 shows, AHCA is concerned that there may be mathematical errors or issues with the CMS payment valuation and simulation modeling that could result in CMS miscomputing and overstating the needed parity adjustment. AHCA urges CMS to review and examine these MDS completion, data submission, and data anomalies issues and evaluate their impact on the agency's estimation of budget neutrality. At a minimum, AHCA urges CMS to phase in the recalibration of the parity adjustment so that anomalies with the underlying data do not lead to an overcorrection of the parity adjustment needed for budget neutrality.

Figure 4: Miscalculation of SNF PPS Rates
(Medicare Rate Changes FY11 To FY12 – Urban)



Skilled Nursing Facility Federal Rates
Federal Registers, July 22, 2010 (FY11), May 6, 2011 (FY12)
Prepared By: American Health Care Association, Research Department, June 1, 2011

C. Data Do Not Support Magnitude Of The Proposed Cut

As noted above, AHCA has grave concerns about the accuracy and magnitude of the proposed recalibration of the parity adjustment to the SNF PPS RUG system. Analysis of data from CMS and the SNF sector suggest that the proposed cut is too large. First, CMS' proposed 12.6% reduction in rates for FY 2012 implies that payments were 14.6% higher under the new RUG-IV system then what they should have been under the old RUG-III system holding utilization and acuity constant.

AHCA could not find government or industry data that would support an implied increase in payment rates of this magnitude. Analysis of data from the CMS Office of the Actuary (OACT) suggests that aggregate Part A SNF PPS expenditure (Medicare program payments plus beneficiary co-insurance) increased by a projected 6.7% between FY 2010 and FY 2011, which is consistent with an annual increase in SNF PPS expenditures of 6.9% per year over the FY 2006 to FY 2011 period). Furthermore, netting out an increase in payment rates due to the market basket update in FY 2010 (1.7%) as well as annual increases in utilization and patient acuity, suggests that there was little or no error in calculating budget neutrality. Similarly, data from a joint AHCA/Alliance (Alliance for Quality Nursing Home Care) survey of nursing facility operators, as well as data from LTC Trend Tracker – AHCA's performance and quality improvement tool for members – suggests that CMS is overestimating the increase in payments associated with RUG-IV implementation by a substantial margin.

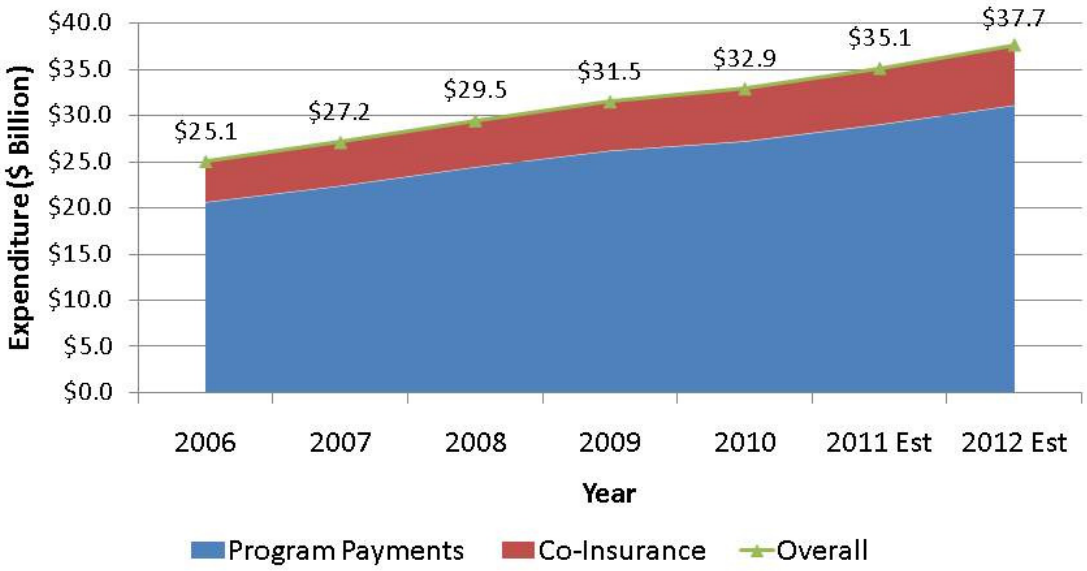
D. Issues with MDS 3.0 Measures: Resident Acuity Did Not Change

Trends in acuity, daily experience in our nursing homes, and conventional wisdom indicate that the acuity of nursing home residents has been growing over time as SNFs provide nursing and rehabilitative services to increasingly elderly, frail and disabled Medicare beneficiaries. It came as a surprise to AHCA when it was suggested by CMS to a nursing home operator that acuity declined on October 1st. Analysis by AHCA that is described further below does show a decline in "measured" acuity based on the MDS 3.0 crosswalked to RUG-III data. To help get to the bottom of this issue, AHCA asked the research organization PointRight to examine changes in SNF resident acuity over time.

As expected and as described in more detail in Appendix A, PointRight found that resident acuity did not decline from FY 2009 through the 2nd quarter of FY 2011. PointRight did find that changes in certain measures and the calculation of other measures did have an effect on elements used to assign residents to RUG groups. For example, PointRight found that changes in the calculation of the ADL score from MDS 2.0 to MDS 3.0 may account for a decrease in the percent of residents with moderate ADL impairment. PointRight also found that the percent of residents with severe cognitive impairment, depression and pain increased with the implementation of new assessment scales in MDS 3.0. While analysis of each factor in isolation can help us to understand the MDS 3.0 issues at play in categorizing residents into different RUG categories, the wholesale revision to the RUG-IV classification system and the complexity of the MDS 3.0 to MDS 2.0 crosswalk, coupled with the condition, treatment, and multiple co-morbidities of the millions of Medicare beneficiaries receiving services in SNFs make it difficult

to identify the issues that appear to be skewing the crosswalked data and overstating the scale of the parity adjustment required to achieve budget neutrality.

Figure 5: SNF Baseline Expenditures Over Time



Source: AHCA analysis of unpublished CMS Office of the Actuary data, Medicare Trustees Report, May 2011.

E. Issues With MDS 3.0 Measures: Unexplained Decline in Measured Acuity: Medicaid

The PointRight data clearly demonstrates no decline in resident acuity. It also illustrates the complex interplay of factors in the categorization of residents under RUG-III both before and after implementation of MDS 3.0 on October 1. The change in assessment instrument in addition to the change in the RUG system makes recalibration of the parity adjustment difficult. In an ideal world the MDS 3.0 crosswalk to RUG-III should yield the same results as if MDS 2.0 data were used to obtain the RUG-III group. Accurate calculation of the parity adjustment factor requires it. Unfortunately, as we demonstrate below, the MDS 3.0 crosswalked data does not appear to map SNF patients into the same RUG group as would have occurred under MDS 2.0. Furthermore, the data show that the MDS 3.0 crosswalked data systematically maps patients into lower paying RUG categories, and consequently appears to overestimate the parity adjustment needed to bring about budget neutrality between RUG-III and RUG-IV.

Data from state Medicaid systems that use RUG-III based PPS systems suggest that there may be an issue with MDS 3.0 resident assessment instrument (RAI) and the cross-walk to RUG-III. Unexplainable reductions in the "measured" acuity of nursing facility residents have occurred since the adoption of MDS 3.0. As shown in Table 1, data from state Medicaid agencies shows that there has been a dramatic reduction in the average acuity level of nursing home patients as calculated from MDS data after the implementation of MDS 3.0 on October 1st. As a result a number of states have not made their regular quarterly acuity related adjustments to Medicaid payment rates in the post October 1st MDS 3.0 based PPS systems because the MDS 3.0-based case-mix indexes (CMIs) were "not reliable" and "due to uncertainties with MDS 3.0" (See Appendix B).

Table 1: Unexplained Decline in "Measured" Acuity (Preliminary Evidence From States)

State	Average Case Mix							
	All Patients				Medicaid			
	3rd Quarter CY 2010	4th Quarter CY 2010	Difference	Percent Difference	3rd Quarter CY 2010	4th Quarter CY 2010	Difference	Percent Difference
Georgia	1.3887	1.3491	-0.0396	-2.85%	N/A	N/A	N/A	N/A
Idaho	1.1667	1.1399	-0.0269	-2.30%	1.0847	1.0523	-0.0325	-2.99%
Indiana	1.2575	1.2609	0.0034	0.27%	1.1528	1.1607	0.0079	0.69%
Iowa	0.9924	0.9617	-0.0307	-3.10%	0.9471	0.9252	-0.0219	-2.31%
Kentucky	1.2240	1.1958	-0.0282	-2.30%	1.1882	1.1582	-0.0300	-2.52%
North Carolina	1.1394	1.1161	-0.0232	-2.04%	N/A	N/A	N/A	N/A
Ohio	2.0815	2.0361	-0.0454	-2.18%	1.9639	1.9124	-0.0515	-2.62%
Virginia	1.1658	1.1345	-0.0313	-2.68%	1.0480	1.0334	-0.0146	-1.39%

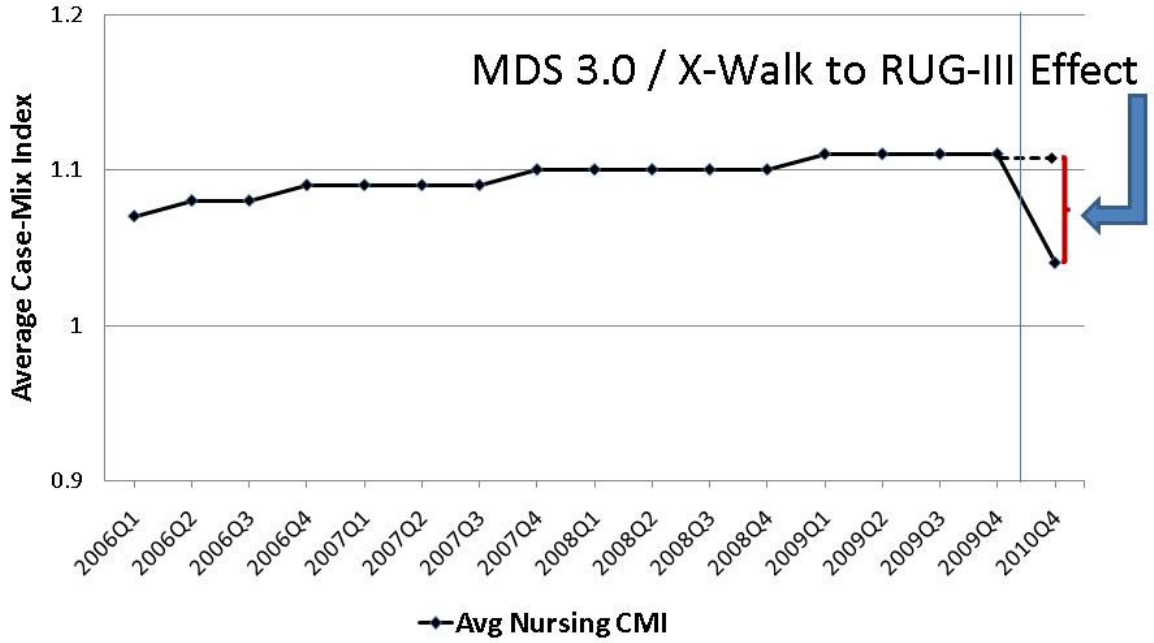
Source: AHCA Research Department analysis of quarterly state RUG-III distribution data provided by state Medicaid agencies

F. Issues With MDS 3.0 Measures: Unexplained Decline in Measured Acuity: Medicare

Moreover, analysis of the CMS parity adjustment methodology by AHCA also suggests that there is an issue with the underlying MDS 3.0 data and the cross-walk to RUG-III in the Medicare SNF PPS. Based on analysis of CMS SNF PPS claims data over the period 2006 through 2009 and supplemental data from the proposed rule, research by AHCA found a dramatic and unexplained reduction in the average acuity level of and average payment rate for

SNF residents under the RUG-III payment methodology post implementation of MDS 3.0 (See Figure 6). AHCA believes that the observed decline in "measured" patient acuity is likely due to an inherent issue with MDS 3.0 and the crosswalk to RUG-III methodology. The unexplained decline in "measured" patient acuity is contrary to historical trends, daily experience, and conventional wisdom. The reason for the observed decline in "measured" acuity is unclear. Nevertheless, irrespective of the reason for the decline, AHCA believes that simulated payments by CMS under RUG-III using MDS 3.0 data appear to result in CMS underestimating payment under the old RUG-III system and as a result CMS may be overestimating the magnitude of the parity adjustment recalibration.

Figure 6: Unexplained Decline in "Measured" Acuity (Average Unadjusted Nursing CMIs Under RUG-III)



Source: AHCA Research Department using CMS SNF PPS 100% LDS SAF data (2006-2009) and FY2011 CMS SNF PPS NPRM supplemental data (Distribution of Part A days by RUG-IV group: FY2011Q1)

G. Proposed RUG-IV Changes Should Be Budget Neutral

The redesign of the new RUG-IV system was multi dimensional. The parity adjustment that sought to maintain budget neutrality under the RUG-III and RUG-IV SNF PPS systems reflected numerous STRIVE project related changes including: an update of the nursing and therapy weights, a reorganization of the RUG classification system to regroup residents into more resource intensity consistent RUG categories, changes to the lookback period for extensive service triggers, introduced allocation of concurrent therapy minutes, adjusted the computation of Activities of Daily Living (ADLs), revised ADL scales, updated depression and cognitive impairment scoring indexes, introduced new start of therapy (SOT) and end of therapy (EOT)

other Medicare resident assessments (OMRAs), changed the completion date for OMRAs to 1 to 3 days, among others. All of these changes together influenced the design of and total unadjusted aggregate payments under the RUG-IV SNF PPS, as well as the payment rates associated with each RUG category.

With this proposed rule, CMS is similarly introducing numerous changes to the design and structure of and incentives under the RUG system including allocation of group therapy minutes, assessment reference date window and grace day changes, new assessments, etc. As with the change from RUG-III to RUG-IV, all of these changes together change the design of the SNF PPS, influence the unadjusted aggregate payments under the SNF PPS, and as such determine the scale of the parity adjustment needed to maintain budget neutrality between the RUG-IV SNF PPS and what one might call the new RUG-IV version 2 (RUG-IV v2) SNF PPS.

In proposing the changes to the design of the RUG-IV system, CMS however failed to incorporate any adjustments to the SNF PPS to ensure budget neutrality between the current RUG-IV and the proposed RUG-IV v2. CMS should evaluate the impact of the proposed RUG-IV v2 changes. CMS should also include these changes as part of it's calculation of the recalibration of the parity adjustment for budget neutrality. Furthermore, recognizing the difficulty in estimating the impact of these proposed changes on the SNF PPS, CMS should phase in the implementation of the parity adjustment recalibration.

H. Recalibration Of The Parity Adjustment Should Be Phased In

As noted above, numerous issues with the recalibration of the parity adjustment portion of the CMS FY 2012 SNF PPS proposed rule give AHCA pause. These include issues with the lack of expenditure data supporting CMS' contention about the magnitude of the increase in spending, data from state Medicaid systems and CMS that show an unsupportable reduction in measured acuity of SNF/NF residents after the implementation of MDS 3.0, and a failure to take into account proposed changes to the SNF PPS that will alter the design, structure, and incentives of the RUG-IV system. Taken together, these issues, coupled with issues related to small sample sizes, utilization seasonality, and various MDS 3.0 transition related technical issues as well as CMS policies that will increase nursing and therapy related costs, suggest that CMS is overestimating the magnitude of the proposed recalibration of the parity adjustment, particularly when CMS has not taken into account the numerous changes to the SNF PPS RUG system for this proposed rule.

Fortunately, there is a solution to this that does not require us to make an educated guess. This solution assures budget neutrality from October 1, 2011 forward, assures that we will ultimately get to the right number, and prevents an unmanageable jolt to the sector.

AHCA proposes that:

- For FY 2012, CMS could reduce SNF PPS rates by up to 3.0 percent plus the productivity adjusted market basket update;
- For FY 2013 and subsequent years, if necessary, CMS could further reduce rates up to 3.0 percent plus the productivity adjusted market basket update until budget neutrality is achieved.;
- In determining budget neutrality, CMS should evaluate and include the impact of the various changes to the SNF PPS RUG system described in the FY 2012 proposed rule (e.g. changes to assessment reference date periods and grace days, allocation of group therapy minutes, implementation of the change of therapy (COT) other Medicare required assessments (OMRAs), introduction of the end of therapy – resumption (EOT-R) OMRA, changes to the EOT OMRA, etc.) - i.e. RUG-IV version 2; and
- If this phase of the budget neutrality adjustment results in overpayments in FY 2012 and beyond CMS should prospectively recover these non-budget neutral overpayments.

The AHCA proposal assures budget neutrality, lets the sector absorb the phased-in reductions while maintaining the level of care for our residents, and does not unduly impact economic recovery. The bottom line is that AHCA's, and CMS' goal is about providing access to quality nursing and rehabilitation services to elderly, frail, and disabled Medicare beneficiaries, while maintaining fair, appropriate, and stable funding. AHCA will be pleased to work with CMS on this proposed rule to provide the services required and meet beneficiary needs in a budget neutral manner that prospectively reflects the complete changes from RUG-III to RUG-IV v2.

II. Budget Neutrality: Phasing-in the Parity Adjustment

(Comments on Section II.B.2: Parity Adjustment)

AHCA Recommendation on the Phase-in of the Parity Adjustment:

- *CMS should implement changes to the SNF PPS RUG system in a budget neutral manner, and*
- *CMS should be consistent in its application of its own long established phase-in policy and thus phase-in any parity adjustments to the SNF PPS RUG system.*

A. Background

As indicated previously, to help get the SNF PPS back to budget neutrality without overshooting it, AHCA is proposing that CMS monitor, reevaluate, and phase-in the recalibration of the parity adjustment. Our proposal is predicated on CMS resolving the MDS 3.0 crosswalk to RUG-III payment underestimation issue as well as other data and methodology issues which appear to have the effect of overestimating the needed parity adjustment recalibration.

In the FY 2012 Proposed Rule, CMS raises the possibility of a phase-in of the proposed parity adjustment but then dismisses it. Specifically, CMS states:

> [W]e considered using an analytical approach that would reflect implementing partial adjustments to the case-mix indexes over multiple years until parity is achieved. However, we believe that such an approach would continue to reimburse in amounts that significantly exceed our intended policy."[3]

Yet, every phase-in approach, by definition, continues to reimburse in amounts that exceed CMS' intended policy. CMS' statement on this point in the FY 2012 Proposed Rule is wholly insufficient to justify ruling out a phase-in of the proposed reduction in light of the magnitude of this reduction.[4] Indeed, the fact that 91% of SNFs fall within the definition of small businesses under the Regulatory Flexibility Act (RFA) further highlights the insufficiency of CMS' consideration of the phase-in as a viable and appropriate alternative.[5]

Phasing in any payment reduction is consistent with CMS' practice of phasing in significant payment reductions to "moderate" the effects of such reductions. Indeed, In the current proposed

[3] 76 Federal Register at 26,372 (May 6, 2011).

[4] Indeed, the fact that phase-in approaches continue to reimburse in amounts that exceed CMS' intended policy has been raised and dismissed in other contexts by CMS. For example, in the IPPS FY 2011 final rule, CMS quotes MedPAC's comments to the FY 2010 IPPS/RY 2010 LTCH PPS proposed rule (74 Federal Register 24,096) "on when CMS should reduce payment rates to prevent further overpayments and to recover overpayments occurring in 2008 and 2009 as follows: 'We support CMS' proposal to reduce IPPS payments in 2010 by 1.9 percent to prevent further overpayments. While we and the CMS actuaries believe that a 1.9 percent reduction will not fully prevent overpayments from continuing in 2010, this is a reasonable first step toward reducing overpayments.'" 75 Federal Register 50,042, 50,061 (Aug. 16, 2010). Yet CMS did not implement the payment adjustment proposed in FY 2010 until FY 2011.

[5] 76 Federal Register at 26,404 (May 6, 2011).

rule for IPPS FY 2012 published on May 5, 2011, CMS confirms that "[i]t is often our practice to phase in rate adjustments over more than one year in order to ***moderate*** the effect on rates in any one year."[6] As illustrated in Appendix C phase-in periods have allocated case mix adjustments proposed for budget neutrality purposes into annual reductions ranging from less than 1% to 4% of the total estimated Medicare payment reductions under the relevant Medicare payment system. This range is well below the 12.6% reduction being proposed for SNF PPS in the Proposed Rule. Examples include:

- To account for nominal changes in case mix in the IPPS, CMS will phase in an adjustment over two years during FYs 2011 and 2012 (specifically, a 2.9% reduction in FY 2011, a 3.15% reduction proposed in FY 2012 which includes an additional 2.9% reduction off-set by a 2.9% restoration of the non-cumulative cut from FY 2011).[7] CMS also plans to take an additional 0.75% reduction at an unspecified time in the future.

- To account for nominal changes in case mix in the IRF prospective payment system, CMS phased-in an estimated $300 million adjustment over two years during FYs 2006 and 2007 (specifically, a 1.9 % reduction in FY 2006 and a 2.6 % reduction in FY 2007).

- To account for nominal changes in case mix in the home health agency prospective payment system, CMS phased-in an estimated $2 billion adjustment over four years for calendar years ("CYs") 2008 to 2011 (specifically, a 2.75 % reduction in CYs 2008 to 2010 and a 3.79 % reduction in CY 2011). An additional 3.79% reduction is currently planned in CY 2012.

As discussed below, a review of CMS' prior use of phase-in periods demonstrates that CMS generally considers three different factors in determining whether a phase-in period or delay is appropriate to "moderate" a proposed payment reduction (or other policy change):

- Whether additional data and/or analysis could improve the accuracy of the proposed payment reduction;

- Whether the proposed payment reduction could cause financial harm or other disruptive effects to providers;[8] and

- Whether the proposed payment reduction could affect the access of Medicare beneficiaries to care.[9]

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[6] 76 Federal Register 25,788, 25,804 (May 5, 2011) (emphasis added).
[7] CMS phased-in every aspect of the change to the MS-DRG system, including a two-year phase-in of the new coding system itself in FYs 2008 and 2009; a proposed three-year phase-in of a prospective adjustment based on nominal case-mix changes in FYs 2008, 2009 and 2010; a two-year phase-in of the recoupment adjustment required under Section 7(b)(1)(B) of Pub. L. 110-90; and a two-year phase-in of the prospective adjustment required under Section 7(b)(1)(A) of Pub. L. 110-90.
[8] *See, e.g.*, 75 Federal Register at 50,061 (Aug. 16, 2010).
[9] 75 Federal Register at 50061.

AHCA maintains that each of these factors is relevant to the current situation. Proper consideration of these factors provides CMS with more than sufficient justification for using a phase-in period for the proposed Medicare payment reduction in this Proposed Rule.

B. Need for Additional Data

At the outset, additional data and/or analysis could improve the accuracy of the proposed payment reduction in the Proposed rule because CMS, itself, admits the "preliminary" nature of CMS' analysis and the incomplete data upon which CMS is basing this "preliminary" analysis.[10] This fact demonstrates that CMS should postpone or phase-in any payment reduction. In previous rulemakings, CMS has presented its "preliminary analysis" for discussion, but this is usually in the limited context of evaluating various policy options or when looking at new data to supplement additional years' worth of publicly available data. The following examples demonstrate the limited context in which CMS relied upon "preliminary analysis" for making major policy adjustments, and in general, the amount of public data available for use in reviewing the agency's "preliminary analysis":

- In the FY 2011 IPPS proposed and final rules, CMS describes RTI's analysis of coding changes for "healthcare acquired conditions," based on 9 months of claims data from FY 2009 ***and*** claims data from two years prior, as a "preliminary analysis."[11] Based in part on this preliminary analysis, CMS decides not to make any changes to the HAC list of conditions.[12]

- The FY 2009 IPPS final rule outlines a thorough retrospective evaluation of claims data that CMS is planning in order to implement payment adjustments in FY 2010 through 2012. CMS describes the preliminary analysis planned for this evaluation "to provide the opportunity for public input" for these planned future activities.[13]

- In the CY 2002 physician fee schedule proposed rule, CMS analyzed six options for making Medicare Economic Index (MEI) productivity adjustments. In discussing CMS' "preliminary analysis" of physician-specific productivity "using the limited publicly available data," CMS stated that this "cannot be interpreted as an official measure of productivity" and that "our rough estimates are inadequate for establishing a formal basis for the productivity adjustment to the MEI."[14]

When comparing these examples to the proposed rule, it becomes even more evident that a phase in period is appropriate to "moderate" the proposed payment reduction included in the Proposed rule. Indeed, CMS' proposed use of "preliminary analysis" to make the proposed $4.47 billion

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[10] 76 Federal Register 26371, 26372, 26373 and 26404.
[11] 75 Federal Register 23,852, 23,880-98 (May 4, 2010) and 75 Federal Register at 50,086 (Aug. 16, 2010).
[12] 75 Federal Register at 50,086 (Aug. 16, 2010).
[13] For example, the FY 2009 IPPS final rule outlines a thorough retrospective evaluation of claims data that CMS is planning in order to implement payment adjustments in FY 2010 through 2012. CMS describes the preliminary analysis planned for this evaluation "to provide the opportunity for public input" for these planned future activities. 73 Federal Register 48,434, 48,450 (Aug. 19, 2008).
[14] 67 Federal Register 43,846, 43,858 (Jun. 28, 2002).

reduction is in stark contrast to CMS' consideration of a parity adjustment in connection with the LTCH PPS. For rate year (RY) 2003, CMS implemented the LTCH PPS in a budget neutral manner and CMS reserved the right to make a future parity adjustment if CMS later determined that the assumptions used by CMS in its budget neutrality calculations "significantly differ[ed]" from actual experience.[15] In the May 11, 2007 final rule, CMS delayed consideration of an LTCH PPS parity adjustment because according to CMS there was still insufficient data to conduct a "comprehensive reevaluation" of these budget neutrality calculations:

> As we discussed in the RY 2007 LTCH PPS final rule (71 FR 27842 through 27844), because the LTCH PPS was only recently implemented, ***sufficient new data had not been generated that would enable us to conduct a comprehensive reevaluation of our BN calculations***.[16]

The import of the administrative and billing changes implemented by CMS on October 1, 2011 to the SNF PPS are analogous to establishing a new prospective payment system in the sense that CMS completely changed the SNF PPS by adopting a new patient classification system (*i.e.*, RUG-IV) and a new patient assessment system (*i.e.*, MDS 3.0) on October 1, 2010. As a result, CMS should phase-in any RUG-IV parity adjustment to allow for a comprehensive reevaluation of CMS' budget neutrality calculations by both CMS and the public as more data becomes available.

C. Destabilization

Also, the magnitude of the proposed aggregate payment reduction, itself (if finalized), could cause financial harm or other disruptive effects to SNFs and could affect the access of Medicare beneficiaries to care thereby justifying a phase in approach. In this regard, the proposed aggregate payment reduction of 12.6% for FY 2012 is significantly larger (almost fourfold) than the recent parity adjustment taken in FY 2010. The parity adjustment taken in FY 2010 was $1.1 billion – already a significant amount – and this amount represented 3.3% of the estimated FY 2010 Medicare SNF payments.[17]

SNFs currently have very low overall total margins and the proposed reduction would likely eliminate any remaining margin and move into negative overall total margins. As a result, the proposed reduction in the Proposed rule is likely to have a significant and widespread destabilizing and disruptive effect on the SNF industry, including the specter of SNF closures similar to what occurred to the SNF industry when CMS introduced the Medicare SNF PPS. As a result, CMS' use of a phase in approach to mitigate the effects of the proposed payment reduction is demanded from the facts and circumstances here.

A detailed review of CMS' prior use of phase in periods to mitigate the potential financial harm of a payment adjustment confirms that the proposed payment reduction in the Proposed rule (if finalized) should be treated similarly with a phase in approach and that CMS has no justification

[15] 72 Federal Register at 26,901 (May 11, 2007)
[16] 72 Federal Register at 26,902.
[17] 74 Federal Register at 40,295 (Aug. 11, 2009).

for treating the SNF industry any differently from other industry sectors. Below is a discussion of IPPS and hospice in this regard.

The current nominal case mix adjustments for the IPPS that are being phased in during FYs 2011, 2012, and beyond illustrate the appropriateness of a phase-in period. As described below, CMS opted to mitigate an aggregate cut of 6.8% (or approximately $7 billion)[18] from IPPS through the use of a 2-year phase-in period for both a retrospective and prospective case mix adjustment.

> After analysis of the FY 2009 claims data for this FY 2011 IPPS/LTCH PPS final rule, we have found a total prospective documentation and coding effect of 1.054. After accounting for the -0.6 percent and the -0.9 percent documentation and coding adjustments in FYs 2008 and 2009, we find a remaining documentation and coding effect of 3.9 percent. As we have discussed, an additional cumulative adjustment of -3.9 percent would be necessary to meet the requirements of section 7(b)(1)(A) of Public Law 110–90 to make an adjustment to the average standardized amounts in order to eliminate the full effect of the documentation and coding changes on future payments. Unlike section 7(b)(1)(B) of Public Law 110–90, section 7(b)(1)(A) does not specify when we must apply the prospective adjustment, but merely requires us to make an "appropriate" adjustment. Therefore, we believe we have some discretion as to the manner in which we apply the prospective adjustment of -3.9 percent. ***Applying the full prospective adjustment*** of -3.9 percent for FY 2011, in combination with the proposed recoupment adjustment of -2.9 percent, discussed below, ***would require an aggregate adjustment of -6.8 percent***. As we discuss more fully below, ***it has been our practice to moderate payment adjustments when necessary to mitigate the effects of significant downward adjustments on hospitals, to avoid what could be widespread, disruptive effects of such adjustments on hospitals***. As we also discuss below, we are required to implement the adjustment in section 7(b)(1)(B) of Public Law 110–90 no later than FY 2012, and accordingly, in the FY 2011 proposed rule, we proposed an adjustment under that section for FY 2011 (75 FR 23870–23871). Therefore, we believe it is appropriate to not implement any or all of the -3.9 percent prospective adjustment in FY 2011. Accordingly, we did not propose a prospective adjustment under section 7(b)(1)(A) of Public Law 110–90 for FY 2011 (75 FR 23868–23870)… .[19]

Similarly, CMS later states in the same IPPS proposed rule:

> ***It is often our practice to phase in rate adjustments over more than one year in order to moderate the effect on rates in any one year.*** Therefore, ***consistent with the policies we have adopted in many similar cases***, in the FY 2011 proposed rule, we proposed to make an adjustment to the standardized amount of -2.9 percent, representing approximately half of the aggregate adjustment required under section 7(b)(1)(B) of Public Law 110–90, for FY 2011. ***An adjustment of this magnitude allows us to moderate the effects on hospitals in one year*** while simultaneously making it possible to implement the entire adjustment within the timeframe required under section 7(b)(1)(B) of Public Law 110–90. As we have previously noted, unlike the prospective adjustment to the standardized

[18] In the IPPS final rule, CMS states: "Our actuaries estimate that this 3.9 percentage point increase will result in an aggregate payment of approximately $4 billion." 75 Federal Register at 50,062 (Aug. 16, 2010). Using simple math, the aggregate cut of 6.8% would translate into approximately $7 billion (($4 billion x 6.8%)/3.9%).
[19] 75 Federal Register at 50,061 (Aug. 16, 2010) (emphasis added).

> amounts under section 7(b)(1)(A) of Public Law 110–90 described earlier, the recoupment or repayment adjustment to the standardized amounts under section 7(b)(1)(B) of Public Law 110–90 is not cumulative, but would be removed for subsequent fiscal years once we have offset the increase in aggregate payments for discharges for FY 2008 expenditures and FY 2009 expenditures. ***In keeping with our practice of moderating payment adjustments when necessary***, we stated that we anticipated that the proposal will have an additional, and significant, moderating effect on implementing the requirements of section 7(b)(1)(B) of Public Law 110–90 for FY 2012.[20]

D. Medicare Beneficiary Access to Care

CMS' phasing in and phasing out of the budget neutrality adjustment factor for hospices as it related to the wage index for hospice payments illustrates ***Medicare beneficiary access to care*** as a factor for justifying a phase-in or phase-out of payment adjustments. In 1997, CMS implemented a new wage index methodology subject to a three-year phase-in period.[21] Significantly, the new methodology for the hospice wage index included a budget neutrality adjustment factor ("BNAF"). Beneficiary access to care was a significant consideration both in developing the then-new actual wage index methodology with the BNAF and the transition to this then-new methodology:

> We agree with the commenter that BNAF was put into place so that beneficiary access to hospice care would be protected. We believe the Committee was primarily concerned about those areas of the country that would see their payments reduced as a result of the wage index change. The Committee was concerned that the payment reductions might affect the viability of hospices in these areas, thus ultimately risking access to care.[22]

CMS recently implemented a three-year phase-out of the BNAF because maintaining the BNAF was outdated. Two of the reasons CMS cited for discontinuing the BNAF are:

> First, the original purpose of the BNAF was to prevent reductions in payments to the majority of hospices whose wage index was based on the original hospice wage index which was artificially high due to flaws in the 1981 BLS data. Additionally, the BNAF was adopted to ensure that aggregate payments made to the hospice industry would not be decreased or increased as a result of the wage index change. While incorporating a BNAF into hospice wage indices could be rationalized in 1997 as a way to smooth the transition from an old wage index to a new one, since hospices have had plenty of time to adjust to the then new wage index, ***it is difficult to justify maintaining in perpetuity a BNAF which was in part compensating for artificially high data to begin with***.

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[20] 75 Federal Register at 50,063 (Aug. 16, 2010) (emphasis added).
[21] 62 Federal Register 42,860, 42,863 (Aug. 8, 1997) (emphasis added).
[22] 73 Federal Register 46,464, 46,470 (Aug. 8, 2008). *See also* 62 Federal Register at 42,883 (Aug. 8, 1997) ("***The Committee considered*** the appropriate data to be used to construct a wage index, the appropriateness of retaining a 0.8 floor, budget neutrality, and ***how to structure a transition to timely update the index yet ensure access to hospice care***. In particular, the Committee considered the problems faced by hospices that would receive significant decreases under the new wage indices, rural hospices, hospices with low wage indices, and hospices that may have disproportionately high non-wage costs." (emphasis added)).

> Second, the new wage index adopted 1997 resulted in increases in wage index values for hospices in certain areas. The BNAF applies to hospices in all areas. Thus, hospices in areas that would have had increases without the BNAF received an artificial boost in the wage index for the past 11 years. ***We believe that continuation of this excess payment can no longer be justified***.[23]

Notwithstanding the outdated aspect of the BNAF and certain payment boosts it was creating, CMS implemented the phase out of the BNAF over a 3-year period:

> We believe that the proposed 3-year phase-out period will reduce any adverse financial impact that the industry might experience if we eliminated the BNAF in a single year.[24]

The American Recovery and Reinvestment Act of 2009 postponed the 3-year phase out by one year and directed CMS to reinstate the BNAF in the calculation of the hospice wage index retroactive to Oct. 1, 2008. CMS then expanded the phase out to a 7-year phase out, starting in FY 2010, due to CMS' own desire to evaluate the impact of the BNAF reduction on CMS' future plans for hospice payment reforms:

> We appreciate the commenters' ***concerns about how the BNAF phase-out would fit into the larger scenario of health care reform***. Health care reform is a major agenda item for the Administration, and may affect the Medicare hospice benefit. We are not clear what the commenter is referring to regarding inconsistent health care spending by state, and believe this comment is outside the scope of our rule. While we cannot speak to the various health care reform measures under discussion in Congress, we continue to believe that the BNAF is an outdated adjustment, for the reasons previously mentioned in this section. However, ***we concur with the commenter that we should evaluate the impact of***

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[23] 73 Federal Register at 46,469 (Aug. 8, 2008) (emphasis added). Another reason cited for the phase out was to bring parity between hospices and HHAs.

> In the proposed rule, we proposed to phase out this adjustment over 3 years, reducing it by 25 percent in FY 2009, by an additional 50 percent for a total of 75 percent in FY 2010, and eliminating it completely in FY 2011. Additionally, ***from a parity perspective, because hospices and home health agencies have a similar labor mix, we believe that adjusting for geographic variances in both of these Medicare home-based benefits with the raw pre-floor and pre-reclassified hospital wage index is appropriate***. 73 Federal Register at 46,468 (Aug. 8, 2008) (emphasis added).

Further, CMS states:

> We continue to believe that the unique BNAF methodology, coupled with the 3-year transition period, served to address those transitional concerns. It also continues to be our belief that because of the growth in the number of hospices, and the growth in the beneficiaries served that has occurred during the last decade, the committee's goal to ensure that access to hospice care not be reduced as a result of the wage index change has been achieved. Therefore, we believe that this unique methodology for achieving budget neutrality has served its purpose and is no longer necessary to be continued. 73 Federal Register at 46,470 (Aug. 8, 2008).

[24] 73 Federal Register at 46,469 (Aug. 8, 2008).

> ***the BNAF reduction in the context of how this type of adjustment will fit into our plans for future hospice payment reform***.
>
> ***A more gradual phase-out provides additional opportunity to evaluate the impact of the BNAF reduction in the context of how this type of adjustment will fit into hospice payment reform***. As we describe in section IV of this final rule, we are moving forward with our plans to collect additional data from hospices to advance our goals for increasing the accuracy of hospice payments. This longer BNAF phase-out ***allows us the opportunity to more thoroughly assess the impact of iterative BNAF reductions while we are performing our hospice payment reform analyses***. As such, we believe that a more gradual phase-out would be appropriate at this time. …
>
> …***We will continue to evaluate the impact of the BNAF***. To move reform forward, we look to the industry for their participation (for example, in providing technical assistance and/or offering to serve as pilot or demonstration sites in testing a new payment system). We reserve the right to revisit the BNAF phase-out should plans for hospice payment reform be delayed, or for other reasons the Secretary deems appropriate.[25]

Appendix C provides additional examples of payment adjustments that CMS has either phased-in or phased-out over a number of years to avoid destabilizing a segment of the Medicare provider industry and to minimize any potential negative impact on the Medicare beneficiary's access to care. To reiterate, we know that the FY 2012 SNF PPS would cause considerable harm to the SNF sector and the care it provides. A reduction of $4.47 billion, coupled with additional Resource Utilization Group (RUG) system changes estimated in the billions and increased costs in the hundreds of millions of dollars, cannot but negatively affect access to care. Implementing these adjustments all at once raises considerable concerns about the financial stability of the SNF sector, and therefore, its ability to continue to provide quality care.

In conclusion, a comprehensive analysis of CMS phase-in policy clearly indicates that payment reductions in these other provider circumstances were at percentages much less than the one CMS is now including in the proposed rule. Yet, CMS failed to propose a phase in approach.

We see no reason why CMS has decided to deviate in the Proposed rule from its own precedent to have a phase in approach for even less dramatic changes in PPS rates seeking budget neutrality adjustments. We ask that CMS be consistent in its application of its own policy and phase-in any parity adjustments for SNFs.

[25] 74 Federal Register 39,384, 39,390 (Aug. 6, 2009) (emphasis added).

III. Parity Adjustment Should Not Skew Payment Rates

(Comments on Section II.B.2: Application of Parity Adjustment)

AHCA Recommendations on Application of Parity Adjustment for Budget Neutrality:

- *CMS should apply parity adjustments for budget neutrality in a way that does not distort SNF payment rates*

A. Background

As noted previously, AHCA is supportive of CMS' efforts to implement RUG-IV in a budget neutral manner, and believes that CMS should implement the numerous changes to the SNF PPS RUG system discussed in the FY 2012 proposed rule in a budget neutral manner as well. AHCA is also supportive of CMS' intent to implement RUG-IV in a way that would "allocate payments more accurately based on current medical practice and updated staff resource data obtained during the STRIVE study, and not to decrease or increase overall expenditures" (74 *Federal Register,* 22237). AHCA agrees that accurate allocation of payments is important, not only for the implementation of RUG-IV but especially on its foundation, the underlying data and basis for the categorization of residents and the relativeness of the nursing and therapy indexes (both within each index, but also between the indexes). Unfortunately, the current methodology for allocation of the parity adjustment and the proposed reallocation of the parity adjustment methodology do not promote rate accuracy, but rather distort payment rates from what they should be.

Currently, CMS applies the parity adjustment as a fixed percentage increase to the nursing weight of each RUG group. The application of a fixed percentage increase to only the nursing component has the effect of skewing and distorting RUG-IV payment rates from what they were and should in the absence of the parity adjustment. To achieve parity without distorting the relativity of the final RUG-IV payment rates, CMS would ideally apply a smaller fixed percentage increase to all four of the components of the RUG-IV payment system. CMS has however rejected this as it lacks the authority to apply the parity adjustment to apply it to all four components. CMS claims that the only lever it has is to apply the parity adjustment through the nursing and case-mix therapy components, and it chose the nursing component it is a component of all of the RUG groups.

B. Proposed Alternative Variable Percentage Methodology

Given CMS' alleged limitations in implementing the parity adjustment and in order to prevent the skewing of payment rates, AHCA proposes an alternative methodology for implementing the parity adjustment. Rather than apply a fixed percentage increase to the nursing component as CMS currently does, under the alternative methodology a variable percentage would be applied to the nursing component. The variable percentage is computed as part of a simple model that computes the percentage increase needed to bring aggregate payments under the old payment

system and the new payment system into balance, applies that percentage to the final payment rates for each RUG group under the new payment system, and automatically solves for the variable percentage parity adjustment increase that is applied to the nursing component of each RUG group under the new payment system. An example of the methodology is included in Appendix D. An excel version of the methodology is also attached for your reference.

C. Applying Different Fixed Parity Adjustments To Rehab RUGs And Non-Rehab RUGs Is Illogical And Creates Payment Distortions: CMS Should Apply Alternative Variable Methodology Or Follow Current Methodology Instead

While the application of a fixed percentage parity adjustment to the nursing component may not be optimal and skews relative payment rates, the CMS proposal to continue to apply a 61 percent parity adjustment to the non-rehab RUG categories and a lower 19.81 percent parity adjustment to the rehab RUG categories is illogical. First, the original 61 percent parity adjustment was determined based on a simplistic RUG-III to RUG-IV transition matrix representing information from about 2,000 Medicare beneficiaries (1,381 on a weighted basis) representing about 1/10th of one percent of the number of 1.7 million Medicare beneficiaries receiving SNF services in any given year. The national distribution of Medicare days by RUG category, representing about 68 million RUG days, were then run through the transition matrix to project days and aggregate payments under the RUG-IV system and compared to simulated aggregate payments under the RUG-III system. Given the weaknesses in the data, it should come as no surprise that the 61 percent parity adjustment is wrong. At the time, AHCA and other stakeholders commented extensively about weaknesses with the data collection methodology, STRIVE data, and manipulations done by the STRIVE project to make the system and the weights work. Given the extent of changes to the MDS and the RUG system, and issues with the STRIVE data and the transition matrix, we noted in our comments that "payment impact analysis based on the proposed RUG-IV system using the STRIVE Medicare resident sample are unlikely to be even reasonably accurate" and that was without considering changes in provider behavior brought on by incentive changes under the RUG-IV system.

Given issues with the data and methodology used to determine the original 61 percent parity adjustment, it is surprising that CMS would defend it's continued usage for non-rehab RUGs. There were many changes to MDS 3.0 and RUG-IV. Some rehab related and many not. Providers responded to the changes in the SNF PPS RUG system both on the therapy side as well as the non-therapy side. New ventilator units are being added. SNF service access issues for residents with medically complex conditions appear to be declining. Given data and methodology issues, coupled with provider responses to the new incentives. it seems inconceivable that the 61 percent parity adjustment was right for non-rehab RUGs, but wrong for rehab RUGs. Moreover, the application of the reduced parity adjustment to rehab RUGs appears punitive. Rather than proceed as proposed, CMS should apply the recalibrated parity adjustment to all RUG categories. AHCA proposes that should CMS examine and adopt the alternative variable percentage parity adjustment methodology rather then the current CMS fixed percentage increase to the nursing component. If CMS is unwilling or unable to implement the alternative

methodology, CMS should continue to use its current parity adjustment methodology that applies a fixed percentage increase to the nursing component of all RUG categories.

IV. STRIVE REDUX: Therapy Weights Need Updating

(Comments on Section II.B.2: Parity Adjustment)

AHCA Recommendation on Updating Therapy Weights to Reflect Delivery of Therapy Services Under RUG-IV:

- *CMS should undertake a STRIVE-like project to update therapy weights to reflect how therapy services are delivered after all RUG-IV related changes have been implemented;*
- *As part of the new project, CMS should collect information on therapy utilization and delivery to update the therapy weights under the RUG-IV system; and*
- *As part of the new project, CMS should examine and refine the categories for rehabilitation RUG assignment.*

The implementation of RUG-IV has and the proposed implementation of RUG-IV v2 will dramatically impact the way therapy is delivered in SNFs. Before the implementation of RUG-IV, CMS/STRIVE estimated approximately 70% of resident therapy minutes were delivered as one-on-one therapy, 28% was delivered concurrently, and around 2% was provided in group settings. Changes to how therapy was recorded in MDS 3.0, coupled with RUG-IV changes that resulted in the allocation of concurrent therapy minutes, unleashed powerful forces that altered the delivery of therapy services post October 1, 2010. Now, under RUG-IV, CMS found that about 91% of resident therapy minutes were delivered one-on-one, about 1 percent concurrently, and about 8 percent in a group setting. The proposed RUG-IV v2 changes will likely dramatically alter the delivery of therapy services again, with more one-on-one, and little or no concurrent or group therapy.

There are also well documented deficiencies with the collection of therapy data and manipulation of the therapy data by the STRIVE project that lead to questions about the accuracy of the STRIVE therapy weights. These deficiencies include:

- Issues with the collection of STRIVE therapy data:
  - Limited and insufficient training provided to rehab staff on using personal data assistant devices (PDAs)
  - Only three days of PDA data on therapy delivery insufficient and potentially misleading
  - No training provided to rehab staff on using paper data collection method
  - Incomplete reporting of therapy time based on paper data collection method
  - Incorrect allocation of combined concurrent/group therapy time (approximately 30% of wage weighted staff time (WWST) could not be identified as concurrent or group)
- Issues with data extrapolation:
  - Paper data unreliable and necessitated extrapolation of 3 days of PDA data to fill in resident therapy time for the week with unknown effect on computation of resident therapy minutes, rehab RUG group assignment

- Extrapolated minutes and rehab RUG group assignment did not match national RUG distribution, resulting in further adjustments such that data did match national RUG distribution

Given the dramatic changes in the delivery of therapy services due to RUG-IV and RUG-IV v2, the STRIVE therapy weights are no longer reflective of the way that therapy services are delivered in SNFs. The cut-points for rehabilitation RUG categorization have not been reviewed nor updated since the establishment of the SNF PPS RUG system. CMS should reexamine and update the rehab RUG cut-points to better reflect new research on improving functional outcomes, changes in resident acuity and the delivery of therapy services, and SNF PPS incentives. The change in delivery of therapy services coupled with inadequacies in the collection of STRIVE therapy data and the manipulations (distortions) introduced to make the therapy weights work, suggest that a new STRIVE study should be undertaken to accurately and sufficiently collect the data required to compute therapy weights reflective of how therapy services are delivered in SNFs. CMS should begin planning for a new STRIVE study now, so that the study can begin in a year or two after providers have adjusted to the RUG-IV and RUG-IV v2 changes that are working their way through the system. AHCA would like to assist in the design and offer our expertise to CMS to update the STRIVE project.

V. Cumulative Market Basket Forecast Error Correction

(Comments on Section I.G.2: Market Basket Forecast Error Adjustment)

AHCA Recommendations on a Cumulative Market Basket Forecast Error Correction:

- *CMS should adhere to the precedent followed in its 2003 actions, which underscored the critical importance of accuracy in payment decisions, by acting decisively when the cumulative impact of market basket forecasting errors erode SNF payment rates by modifying the agency's threshold policy to apply a cumulative correction for market basket forecasting errors when the 0.5% threshold is reached on a cumulative basis.*

In 2003, CMS instituted two adjustments to the market basket to account for market basket forecasting errors. First, CMS made an adjustment to the market basket rate to account for the cumulative effect of forecasting errors covering the period FY 2000 through FY 2002. The adjustment resulted in a one-time 3.26 percentage point increase which was reflected in FY 2004 SNF PPS rates. At the same time, CMS also instituted a process for annual adjustments for market basket forecasting errors when the difference between the forecasted and actual change in the market basket exceeds a certain threshold in any given year. For FY 2003 through FY 2005, the threshold was set at 0.25%, and for FY 2006 onwards the threshold was raised to 0.5%. For FY 2011, CMS reduced Medicare Part A payment to SNFs by 0.6% to correct for an error in forecasting the market basket in FY 2009. Taken together AHCA estimates the uncorrected cumulative market basket forecasting error has been 0.7%, since the last cumulative adjustment in 2003.

Table 2: Annual Market Basket Forecasting Error Since Correction in FY 2002

Federal Register Providing Actual Market Basket Update	Fiscal Year	Predicted Market Basket Update	Actual Market Basket Update	Percentage Point Difference
July 30, 2004 69 FR 45778	FY 2003	3.1%	3.3%	0.2%
August 4, 2005 70 FR 45029	FY 2004	3.0%	3.0%	0.0%
July 31, 2006 71 FR 43162	FY 2005	2.8%	2.9%	0.1%
August 3, 2007 72 FR 43415	FY 2006	3.1%	3.4%	0.3%
August 8, 2008 73 FR 46419	FY 2007	3.1%	3.1%	0.0%
August 11, 2009 74 FR 40292	FY 2008	3.3%	3.6%	0.3%
July 22, 2010 75 FR 42891 (Annual adjustment made)	FY 2009	3.4%	2.8%	-0.6%
May 6, 2011 76 FR 26369	FY 2010	2.2%	2.0%	-0.2%

In 2003, CMS chose a threshold of 0.25%, and raised it to 0.5% in 2006, contrary to AHCA's position in public comments. The threshold, however, has functioned as CMS intended, and forecast errors less than the threshold have been permitted to remain standing. While not in favor of the 0.25% threshold then and especially not in favor or the 0.5% threshold now, the industry has accepted the process and the threshold.

At the same time, we believe CMS in the 2003 rule making set a precedent that the agency understood the cumulative erosive impact of forecast errors over time, and by its actions of adjusting for the cumulative impact of multi-year forecasting errors acknowledged the agency's obligation to make corrections. We further believe that the policy adopted in 2003 recognized the cumulative impact of forecast errors in prior years, and set the precedent for corrective action when errors compound over a multi-year period.

As such we ask that CMS adhere to the precedent followed in its 2003 actions that underscored the critical importance of accuracy in payment decisions and act decisively when the cumulative impact of errors erode rates by apply a cumulative adjustment for market basket forecasting errors when the cumulative forecasting errors reach the 0.5% threshold. AHCA believes that such a policy and threshold is tolerable only if a correction is made when the forecast error cumulatively reaches the specified threshold.

VI. Non-Therapy Ancillary Services

(Comments on Section III.A: Prospective Payment for SNF Non-Therapy Ancillary Costs)

AHCA Recommendations on Non-Therapy Ancillary Services (NTAS):

- *AHCA is broadly supportive of CMS' efforts to improve reimbursement for NTAS in the SNF PPS;*
- *AHCA is broadly supportive of CMS' efforts to develop a separate NTAS component and index or reasonable NTAS end-split in the SNF PPS RUG system that:*
    - *Uses information from available SNF administrative data sources;*
    - *Uses variables that are highly predictive of resource use, clinically sensible, and sensitive to patient NTAS utilization;*
    - *Appropriately incentivizes providers;*
    - *Collects additional information from SNF administrative data sources after due consideration and evaluation of the additional information on developing and allocating NTAS payments and provider costs and administrative burdens;*
    - *Includes a base payment for every patient day tht covers the cost of routine NTAS;*
    - *Includes a tiered payment to reflect and better target NTAS payments to patients with high non-routine NTAS costs;*
- *CMS should examine and design the NTAS component such that it reflects and accurately pays for NTAS services particularly those included under consolidated billing;*
- *CMS should examine and design the NTAS component so that it captures and accurately pays for broad classes of high cost drugs or pays based on an annually updated list of high cost drugs administered by the Secretary;*
- *CMS should continue to examine and explore the development of a NTAS component using existing data sources such as MDS 2.0, but the final analysis and design of the NTAS component before implementation should be based on currently used administrative data (i.e. MDS 3.0);*
- *CMS should explore the development of an outlier policy for NTAS including a cost pass through for high cost drugs and equipment; and*
- *CMS should involve stakeholders such as AHCA early in the process to inform the research and provide technical expertise on the development of a modification to the SNF PPS that better aligns NTAS costs with payments*

A. Background

The SNF PPS pays for non-therapy ancillary services (NTAS) through the nursing component of the RUG system. In developing the SNF PPS, CMS determined the approximate percentage of non-therapy ancillary costs included in the nursing component of the urban rate to be 43.4%, and 42.7% of the nursing component of the rural rate.

The SNF PPS does a poor job of reimbursing SNFs for NTAS. Research by MedPAC and for AHCA by the Lewin Group found that the SNF PPS (under RUG-III) explained only about 5%

of the variation in stay level NTAS costs. Analysis by the Lewin Group also found that the top 5% percent of NTAS cases are responsible for about 40% of NTAS related expenditures. In addition, analysis by the STRIVE project found that acuity based on the nursing index explained about one-hundredth of one percent of the variation in daily drug costs. Most importantly, the STRIVE project found that high pharmacy costs are driven not by patient utilization of a large number of drugs but rather by one or two high cost drugs.

B. Basic Principals For SNF PPS NTAS Reform

In the proposed rule, CMS requests comment on the criteria to be used to develop a NTAS component and the proposed conceptual model. Overall, AHCA supports CMS' efforts to develop a separate NTAS component and index or workable NTAS end-split in the SNF PPS RUG system. AHCA is also broadly supportive of the concept that the CMS approach to refining the SNF PPS to better target NTAS costs to payments should:

- Uses information from available SNF administrative data sources;
- Uses predictor variables that are highly predictive, clinically sensible, and sensitive to patient NTAS utilization;
- Appropriately incentivizes providers;
- Collects additional information for SNF administrative data sources with due consideration for the administrative cost and burden of collecting the information and examining least costly and burdensome alternatives;
- Includes or reflects a base payment for every patient day that covers the cost of routine NTAS; and
- Includes or reflects a tiered payment to reflect and better target NTAS payments to patients with high non-routine NTAS costs;

As such, AHCA is in principal supportive of an SNF PPS payment system that reflects a base payment for routine NTAS costs, and a limited number of increasingly costly tiers of similarly expensive non-routine NTAS items. CMS could implement this as a separate NTAS component or applied as a routine NTAS component to the nursing or non-case mix weight and a workable NTAS end-split in the SNF PPS RUG system. An outlier policy may be necessary if a tiered system cannot be designed to accurately capture high cost drugs. Alternatively, AHCA could envision an cost pass-through policy for the most expensive drugs rather than an outlier policy, as we see little reason why providers should be paid 80 cents on the dollar for ever more expensive emerging drug regimens.

C. SNF PPS NTAS Reform And Consolidated Billing Issues

AHCA concurs with research conducted for CMS that the highest-cost ancillary services are generally used by a small subset of the SNF population, and that the high and varied cost of individual services or drugs by these populations – rather than the volume of NTAS utilization – can at least partially explain the wide variance in NTAS costs. Another key reason for the wide variation in NTAS costs is related to consolidated billing. CMS should examine the effect of

consolidated billing on costs and payments, and design the NTAS component to reflect and accurately pay for NTAS services taking into account site of service issues.

Since the implementation of the SNF PPS, the type of services included in SNF consolidated billing have changed as hospital outsource diagnostic services and free-standing diagnostic centers have proliferated. CMS designed the SNF PPS in an era when SNFs could send patients to hospital outpatient departments for diagnostic services that were billable under Part B. Now, SNFs increasingly send patients to free-standing diagnostic centers where they bear the full cost of the services because of consolidated billing site-of-service requirements. For example, for some providers, such as a hospital based SNF or a rural SNF, the SNF may have access to diagnostic services that can be billed by the hospital outpatient department to Part B. The SNF does not incur the cost of the diagnostic service. In other settings or at other times, the SNF may incur the cost of the diagnostic service. If the service is provided in a free-standing outpatient diagnostic center, the cost of the procedure would be borne by the SNF. Additionally, the cost to the SNF for the service could vary based upon the contractual agreement between the two parties from the Medicare fee screen amount up to the diagnostic center's usual and customary charges. Furthermore, the impact is not consistently applicable. Access to hospital or free-standing diagnostic services could vary depending on the type of service, the day of the week, diagnostic equipment availability, etc. All these issues together make it difficult to determine the total cost for NTAS services, to develop and determine appropriate weights for a tiered non-routine NTAS component, and development of a standard approach for the payment of NTAS across provider types and geographic areas

The site of service issue and the variability issue will skew the NTAS data in unobservable and indeterminate ways. A NTAS system build on incomplete and skewed data could significantly misalign payments for NTAS services, and the misalignment could vary across provider and day to day. This is a serious issue that does not appear to have a ready solution. Getting the absolute and relative NTAS weights and rates right will be difficult with incomplete and unobservable and indeterminate data. The introduction of additional NTAS related information on the MDS will not resolve the absolute and relative weight problem. It will only assist in developing a NTAS system that pays at the right NTAS tier, and not whether the absolute and relative weighting for that tier is right. Implementation of a NTAS system using current information to define and weight the tiers and using additional MDS data to identify the NTAS cost drivers as well as resolve the consolidated billing related issues is possible. CMS needs to take into consideration all factors and implications of the numerous scenarios related to SNF consolidated billing and to assure that the current inconsistencies in payment and financial responsibility be addressed in the development of options to modify the payment for SNF Part A NTAS.

D. MDS 3.0, RUG-IV And SNF PPS NTAS Reform

CMS NTAS models and associated outlier models will need to be revised and updated before they can be implemented in a MDS 3.0 / RUG-IV based SNF PPS. Without updating, CMS will continue to make payments for NTAS at inappropriate levels, particularly as providers modify practices in response to changing policies, requirements and incentives under the evolving RUG-IV SNF PPS. While current research can help develop the basic structure for improved payments under a SNF PPS for NTAS, the exact formulation of the components, associated

relative payments between tiers, and the appropriate allocation of costs and payments between routine, non-routine and outlier portions of NTAS could vary considerably depending on data under the new payment structures.

E. NTAS Reform And The Nursing Component

In the proposed rule, CMS indicates that payments associated with a new NTAS component of the SNF PPS would be financed by reallocating the portion of the current nursing component which has been previously considered to account for NTAS costs. Payment redistributions resulting from a shift of NTAS related payments out of the nursing component into a new NTAS component increase the importance of getting the nursing weights right. Similarly, establishment of an outlier policy for NTAS would shift payments from low NTAS utilization facilities to high NTAS utilization facilities. Though it may result in an improvement in SNF PPS payment accuracy, it again shifts funds and increases the importance of having the nursing component weights accurately reflect relative routine costs. CMS should examine and evaluate whether a revised and improved STRIVE like study could help to ensure that the nursing weights are "right".

We would also recommend that CMS test its final NTAS payment model for payment compression. By this we mean the extent to which the system pays accurately at the extremes of low and high cost cases. This is particularly important for NTAS costs as they are unevenly distributed to a few cases. Compression can be checked in two ways. First the facility level CMI regression coefficient should be about 1.0. This means that as CMI increases 10%, costs also rise 10%. Another test for payment compression is to predict payments for high cost cases and determine the ratio of predicted payments to actual costs. Again, prediction ratio of 1.0 Is ideal. MedPAC has advanced both of these standards.

F. AHCA And NTAS Reform

AHCA is interested in getting NTAS reform right. The SNF PPS does a poor job of reimbursing SNFs for NTAS. AHCA is encouraged that CMS is working to establish proper and appropriate incentives for SNFs and to improve the SNF PPS to better align NTAS costs and payments. As with other changes to the RUG system, CMS should implement NTAS reforms to the SNF PPS in a budget neutral manner. AHCA is interested in working with CMS to reform NTAS. CMS should involve stakeholders such as AHCA early in the process to inform the research and provide technical expertise to improve payment for NTAS.

VII. Wage Index Reform

(Comments on Section II.C: Wage Index Adjustment to Federal Rates)

AHCA Recommendations on Wage Index Reform:

- *AHCA opposes the development and imposition of a SNF area wage index that still only reflects the cost or price of labor in the hospital setting, which could again lead to the establishment of a new system with reclassification adjustments. Any revisions to the area wage index methodology should be appropriately applicable to both hospitals and LTPAC settings;*
- *AHCA encourages CMS to develop an improved area wage index methodology using data that reflects the price of labor rather than the cost of labor and that appropriately adjusts Medicare payments for geographic labor price and thereby resolves the boundary effect issue for hospitals and providers across the health care spectrum;*
- *Any reform to the design, development, and implementation of the hospital wage index must be eventually applied to SNFs and other LTPAC settings;*
- *AHCA supports the development of an improved wage index methodology that would rely on more appropriate data, which would eliminate the need for reclassification, and provide a mechanism for appropriately adjusting payment systems for differences in the price of labor in local markets;*
- *AHCA is broadly supportive of using U.S. Bureau of Labor Statistics (BLS)-type data reflecting the price of labor for all health care sector employers in the development of a wage index for hospitals and for LTPAC settings, as recommended by the IOM;*
- *AHCA is supportive of efforts and appropriations to have CMS work with BLS and collect BLS-type survey data from all Medicare-and/or Medicaid-certified hospital and LTPAC providers on an annual basis;*
- *AHCA supports the collection of information on commuting patters for all LTPAC settings, and not just for hospital employees, in order to make adjustments to the wage index methodology to resolve the boundary effect issue; and*
- *CMS should phase-in any new wage index methodology, particularly one that resolves the boundary effect issue, to allow providers the opportunity to adjust their labor costs over time.*

A. Background

The current area wage index methodology for adjusting Medicare payments is broken. It does not appropriately, nor adequately adjust Medicare payments for differences in wage rates across geographic regions for hospitals or, especially for post-acute care providers. The Medicare Payment Advisory Commission (MedPAC), Acumen LLC, the Institute of Medicine (IOM) and others have researched and described the deficiencies with the current data and methodology, and made recommendations on reforming the system.[26] The research conducted for CMS by

[26] See MedPAC (2007). *Report to the Congress: Promoting Greater Efficiency in Medicare*, June; Acumen LLC (2008). *Impact Analysis for the 2009 Final Rule: Interim Report: Revision of Medicare Wage Index*, August; Acumen LLC (2009). *Revision of Medicare Wage Index: Final Report: Part 1*, (April); Acumen LLC (2010).

Acumen, LLC shows promise in terms of refining the area wage index. Work by the IOM suggests numerous implementable reforms that could significantly improve the hospital wage index, as well as a wage index for various long term and post acute care (LTPAC) settings. We encourage CMS to develop an improved area wage index methodology using data that reflects the price of labor rather than the cost of labor and that appropriately adjusts Medicare payments for geographic labor price and thereby resolves the boundary effect issue for hospitals and providers across the health care spectrum.

MedPAC's June 2007 *Report to the Congress: Promoting Greater Efficiency in Medicare* identifies several critical problems with the current area wage index methodology, including:

1. Large differences in wage indexes between adjoining geographic areas that have led to the establishment of numerous exceptions, which allow hospitals to be reclassified to other geographic areas;
2. Implementation of an additional annual occupational mix survey for each hospital to adjust the wage index for the skill level of employees;
3. Circularity in the establishment of the wage index, whereby hospitals located in markets with few providers have the ability to set or influence the wage index for their geographic area through business practices; and
4. Year-to-year volatility of the wage index within a geographic area that does not appear to be related to underlying changes in local labor market conditions.

B. Reclassification Puts SNFs At A Competitive Disadvantage

For years, AHCA has advocated that use of an area wage index methodology, which relies on hospital cost report data to create an index for SNFs and other post-acute care settings, is seriously flawed. Hospitals have been able to address to some extent weaknesses in the current methodology through extensive use of numerous geographic reclassification adjustments. The issue is such that approximately forty percent of hospitals have exceptions and reclassifications. CMS' failure to develop a SNF-specific area wage index and the limitations set by the Congress does not permit SNFs to make similar geographic reclassification adjustments to offset the deficiencies in the area wage index methodology. Consequently, a great divide now exists between the hospital and the SNF area wage indexes in those areas where hospitals have been reclassified. This divide seriously disadvantages SNFs and other post-acute care providers in terms of recruiting and retaining critical direct care staff and offering competitive and perhaps even adequate wages. Such well-documented, systemic weaknesses in the area wage index methodology and reclassification system should not be permitted to continue. Immediate action is needed to fix this inequitable system.

Revision of Medicare Wage Index: Final Report: Part 2, (March); Acumen LLC (2011). *Revising the Medicare Wage Index to Account for Commuting Patterns*, (April); and IOM (2011). *Geographic Adjustment in Medicare Payment: Phase 1: Improving Accuracy*. (June).

C. The Institute Of Medicine & Geographic Adjustment

On June 1, 2011, the Institute of Medicine (IOM) released a report, which is entitled, *Geographic Adjustment in Medicare Payment: Phase 1: Improving Accuracy*. AHCA was pleased that the report identified key principles and made recommendations for reforming the hospital wage index and the physician geographic practice cost index. AHCA is also pleased that the IOM made recommendations for reform for facilities (other than short-term, acute care hospitals) such as skilled nursing facilities or other LTPAC providers. Any reform to the design, development, and implementation of the hospital wage index will eventually be applied to SNFs and other LTPAC settings.

AHCA is encouraged that the IOM recommendation includes data that would come from all health care providers. AHCA remains hopeful that CMS will soon develop a wage index representing the SNF setting that is based on all healthcare employer data and SNF-specific occupational mixes. Such an index for SNFs and other LTPAC settings would adjust for the price of labor and be reflective of the labor markets where we operate, as well as control for our setting specific occupational mixes.

D. A New Wage Index Methodology Is Needed

Given the extent of the problems with the current area wage index methodology and its lack of application in both hospital and especially LTPAC settings, AHCA supports the development of an improved wage index methodology that would rely on more appropriate data, which would eliminate the need for reclassification, and provide a mechanism for appropriately adjusting payment systems for differences in the price of labor in local markets. We are encouraged that MedPAC, Acumen, and the IOM recognize that a system based solely on hospital labor cost data is inappropriate. We ask that CMS consider recommendations from MedPAC, Acumen, and the IOM that call for the wages and benefits data, used to create an area wage index to better reflect the price of labor in a broader context, to include SNFs and other post-acute care settings. This coupled with national occupational mix data for each LTPAC setting would make for a much more accurate wage index.

E. Wage Index Methodology: A Hospital Only Application?

AHCA is broadly supportive of using U.S. Bureau of Labor Statistics (BLS)-type data reflecting the price of labor for all health care sector employers in the development of a wage index for hospitals and for LTPAC settings, as recommended by the IOM. Using BLS-type wage data representing a broad range of care settings would greatly improve the current system and form a solid foundation for a new wage index. AHCA also supports the IOM recommendation, which would allow CMS full access to the BLS data needed to compute the wage index, to use data for all occupations and use fixed national occupational weights for each LTPAC setting to create an index that reflects the national labor share and provider type.

AHCA, however, has a concern regarding the use of BLS data to construct a hospital compensation index as recommended by Acumen and the IOM. Our principal concern relates to the sufficiency of the data of the various provider settings in the construction of the wage index for the various provider settings. For instance, the IOM study indicated that IOM did not test the accuracy of the BLS statistics for individual health care settings, such as SNFs. We are also concerned about the accuracy and transparency of the data used to make the adjustments. The IOM correctly noted that the geographic adjustment process should allow empirical review of the data and methods used to make the adjustment. Anonymous BLS survey data from a 3- to 5-year rolling sample of providers in various geographic markets does not allow for empirical review and identification and correction of outlier "erroneous" data.

AHCA is supportive of efforts and appropriations to have CMS work with BLS and collect BLS-type survey data from all Medicare-and/or Medicaid-certified hospital and LTPAC providers on an annual basis. For instance, CMS could implement and collect data for a BLS-type survey of certified providers, which could be supplemented with BLS survey data from other provider settings if necessary and as appropriate. Because such data would be collected from Medicare/Medicaid-certified providers, CMS could make the aggregated data available to the public for replication, review, and identification of data anomalies. Alternatively, the BLS survey could be modified to allow for the recording of some type of provider identifier (the Medicare/Medicaid federal provider number, for example), and CMS could require Medicare or Medicaid certified providers to provide this information on the BLS survey to allow CMS to utilize the data for development of the wage index. BLS and CMS could also work together to send the survey out to all Medicare or Medicaid providers annually, with an appropriate indicator for whether the particular provider survey was for the CMS sample frame, the BLS sample frame, or both. Doing so would help to achieve accuracy and transparency goals of the IOM, CMS, and providers and would help to ensure that the data, methodology, and the wage index for each setting is appropriate, accurate, and reflective of geographic differences in the input price of labor.

F. Any New Area Wage Index Methodology Should Apply Across Health Care Settings

AHCA opposes the development and imposition of a SNF area wage index that still only reflects the cost or price of labor in the hospital setting, which could again lead to the establishment of a new system with reclassification adjustments. Any revisions to the area wage index methodology should be appropriately applicable to both hospitals and LTPAC settings.

AHCA is pleased with the IOM recommendation that CMS "should use respective labor share and occupation-specific weights" to develop the wage indexes for other non-inpatient PPS facilities. An appropriate wage index for the various LTPAC settings, however, goes beyond labor shares and weights, and should be based on data and reflect the price of labor for each LTPAC setting. The BLS collects wage data from 800 occupations and 450 industries. By using all health sector industry data, a wage index reflecting prevailing market wages can be constructed.

G. Resolving The Boundary Effect Problem

AHCA is broadly supportive of the Acumen and IOM proposals to adjust the wage index to better reflect commuting patterns of employees. Smoothing adjustments according to commuting patterns will go a long way toward ending the desire for geographic reclassification and create a more even playing field where SNFs and other LTPAC providers can compete with hospitals for skilled labor. It is critical that any such adjustment be built on more than hospital commuting patterns. Commuting patterns for health care workers employed by SNFs differ from those of hospital employees. CMS should collect the necessary data from SNF and other LTPAC providers to be able to construct specific commuting pattern adjustments based on provider type or commuting pattern adjustments across the entire healthcare sector. Hospitals are not the focal point of post-acute care labor markets, so any revisions to labor market definitions and commuting pattern adjustments should be appropriately applicable to hospitals and LTPAC settings alike.

We have carefully reviewed all of the current boundary solutions. If any one of them should be implemented, some sort of a phase-in approach would be necessary.

H. AHCA And Wage Index Reform

It is critical that we get wage index reform "right". The wage index methodology used to adjust Medicare payments for SNFs, other LTPAC providers, and inpatient hospitals is broken. AHCA is encouraged that CMS is working to improve the wage index methodology. AHCA encourages CMS to break down silos and other barriers within CMS to reform the wage index in a way that will work for both acute and LTPAC settings, and not just for inpatient hospitals. AHCA encourages CMS to have AHCA and other LTPAC stakeholders in addition to acute setting stakeholders involved in the process for reforming the wage index.

VIII. Wage Index and Budget Neutrality: Why Isn't It?

(Comments on Section II.C.: Wage Index Adjustment to Federal Rates)

AHCA Recommendations on a SNF Wage Index Adjustment:

- *CMS should review its SNF wage index adjustment methodology, adjust its methodology as necessary to ensure that it is applied correctly as per statute in a manner that does not result in aggregate payments that are greater than or less than would otherwise be made in the absence of the wage adjustment, and make any necessary adjustments to make up for past wage index related underpayments.*

As we noted in our comments last year, AHCA believes that CMS is misinterpreting Section 1888(e)(4)(G)(ii) of the *Social Security Act* (the Act) as it applies the wage index to SNFs.

Specifically, the provisions of the Act related to the wage index are as follows *(emphasis added)*:

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

AHCA used its SNF PPS reimbursement simulation model to estimate SNF PPS payments under alternative wage index scenarios. For our analysis, we utilized 2009 patient days from the CMS claims files, and information on the federal rates, and nursing and therapy weights for FY 2012 to determine total SNF Medicare payments. We ran the calculations using the FY 2012 wage index and without a wage index adjustment (setting the wage index to 1.0000). While we were able to more or less replicate the CMS methodology, AHCA found that aggregate SNF reimbursement were about $400 million lower with a wage index adjustment than without it. Since this methodology appears to have been in place since the implementation of the SNF PPS, we estimate that the incorrect application of the budget-neutral wage index adjustment has under-reimbursed SNFs by nearly $3 billion over the period from 2002 through 2011.

After reviewing the statute, and the CMS and AHCA methodologies, AHCA believes that CMS is utilizing a wage index budget neutrality adjustment methodology that is inconsistent with the statute. We ask CMS to review the statute and the Agency's wage index adjustment methodology. We also ask CMS to correct the wage index calculation so that aggregate payments to SNFs are the same with and without the wage index adjustment, as required by statute. Further, we request CMS to review its wage index calculations since implementation of the SNF PPS. If we are correct, we request that CMS make a one time adjustment to reimburse SNFs for the cumulative underpayment due to the observed non-budget neutral wage index adjustment methodology, or implement another reasonable and acceptable alternative.

IX. Group Therapy

(Comments on Section V.C: Group Therapy and Therapy Documentation)

AHCA Recommendations on the Allocation of Group Therapy Minutes:

- *Adjustments to group therapy under the SNF PPS RUG system should recognize and fairly reimburse for higher group therapy related costs;*
- *CMS should examine alternatives that address overreaching incentives in the SNF PPS for providing group therapy, without negatively impacting beneficiary functional outcomes, nor penalizing SNFs that provide group therapy services;*
- *CMS should examine changes to the current cap on group therapy minutes to reduce the incentive to over-utilize group therapy;*
- *If CMS decides to allocate group therapy minutes, CMS should allocate group therapy minutes based on actual group size and recognize and reimburse for the increased cost of providing group therapy services;*
- *As an interim step, if CMS decides to allocate group therapy minutes, CMS should adjust group therapy minutes based on average group size; and*
- *Any adjustments to group therapy in the SNF PPS RUG system should be implemented in a budget neutral manner.*

A. Background

Upon its inception, the STRIVE project held out the prospect for better understanding the delivery of therapy services and update the payment system to better reflect how therapy services are delivered in SNFs. Unfortunately, because of flaws in the design and implementation of the STRIVE project, the data on therapy services delivery and the weights derived from it were inaccurate and required significant adjustment. The changes induced by RUG reform have further altered the delivery of therapy services in SNFs such that the updated therapy weights no longer reflect how therapy is delivered in SNFs.

CMS has proposed a number of changes to how it will pay for group therapy services. The reforms introduced as part of RUG-IV, have induced dramatic changes in the delivery of therapy services. Before the implementation of RUG-IV, CMS/STRIVE estimated that about 70% of therapy was provided as one-on-one therapy, 28% was provided concurrently, and about 2% was provided as group therapy. As part of the RUG reforms, CMS halved concurrently provided resident therapy minutes in its calculation of total resident therapy time. This change, among others, changed the incentive system. By adjusting concurrent therapy minutes, and not adjusting group therapy minutes, CMS established an incentive under RUG-IV to provide therapy in group sessions rather than in concurrent sessions. SNFs and therapy companies providing services to SNFs responded to the incentives by scheduling the therapy day so that multi-patient treatments (when they are indicated) are more likely to be provided for patients who are doing similar activities (group) rather than patients who are doing different activities (concurrent). As part of the proposed rule, CMS seems to want to reduce the incentive to provide group therapy by

quartering resident therapy minutes provided during group sessions in the calculation of total resident therapy minutes.

With the adjustment to concurrent therapy, CMS should have expected some shift in the mode of therapy services from concurrent to individual and group. They did not. CMS seems to believe that there has been a significant increase in group therapy that they feel needs to be addressed in the SNF PPS. But did the provision of group therapy change very much? The evidence is inconclusive. Under RUG-III and with MDS 2.0, no data were collected on the modality of therapy delivery in SNFs. CMS has interpreted the STRIVE findings to suggest that very little group therapy was delivered. But the STRIVE data itself do not provide a definitive answer. The STRIVE project found that over 25% of physical therapy and occupational therapy and over 15% of speech language pathology therapy were delivered as concurrent or group therapy.[27] In estimating group and concurrently provided therapy, CMS or the STRIVE project appears to have allocated the combined group/concurrent minutes in the ratio of concurrent to group based on the clearly identified concurrent and group therapy time. This may not have been an appropriate allocation of the combined minutes, and as such appears to show a spike in the provision of group therapy post October 1 because the underlying group therapy baseline may be wrong. CMS should certainly examine the role of group therapy and make adjustments if necessary as part of a recalibration of the parity adjustment, but the data do not necessarily support a need to allocate group therapy time.

B. Allocation Of Minutes Disincentivizes Concurrent And Group Therapy: Additional Incentives Needed

It is important to note that the issues that CMS appears to be struggling with are the cases at the margin, where it is appropriate for a beneficiary to receive individual or concurrent therapy, or individual or group therapy. Where individual is appropriate, the patient will continue to receive individual one-on-one therapy. Where group is appropriate, the patient will continue to receive group. The exception is likely to be concurrent, because where concurrent is appropriate, the patient will likely receive individual because of the financial penalty for providing concurrent, unless labor constraints are such that the only way to provide the service is to offer it concurrently.

Under the old RUG-III system, therapists in situations where the beneficiary needs could be equally met through individual or concurrently provided therapy had an incentive, to provide concurrent therapy to improve therapist productivity, to increase the number of residents receiving concurrently provided therapy, and increase the number of residents receiving therapy in a group setting, above what is reflected in the therapy weight. The limitation of two people for concurrently provided therapy would have limited the incentive to provide therapy concurrently, without negatively affecting productivity, and still meet beneficiary needs. The CMS adjustment to concurrent minutes reduced the incentive to furnish therapy concurrently as evidenced by the CMS data, and impacted therapy productivity negatively.

[27] STRIVE Technical Expert Panel Meeting, March 11, 2009. Slide 34.

Given the negative impact on productivity and reimbursement for services, adjustment to concurrent therapy minutes established an incentive to provide therapy in small groups in situations where the beneficiaries' therapy needs could be equally met through individual or group provided therapy. Limiting concurrent to only two individuals and taking away adjustment to therapy minutes would have reduced the incentive for group services that CMS created, provide incentive for more efficient delivery of therapy services where warranted, and take away the incentive to over-utilize concurrent therapy. CMS should take a fresh look at keeping the limitation on two person concurrently provided therapy and negatively impacting therapy productivity, and remove the payment penalty for providing concurrently provided therapy.

C. Proposed 4-Person Group Allocation: Not Remotely Ideal

In order to reduce the incentive to over-utilize group therapy, CMS "believes" that the optimal number of patients for group therapy is four and proposes to allocate group therapy minutes based on a 4-person group irrespective of whether there are only 2, 3, or 4 patients in the group. CMS' belief is faulty. There are numerous instances when 2-person or 3-person group is effective and in some cases superior to 4-person group. There are also instances where 4-person group could pose serious patient safety risks. It should be up to the treating therapist to determine the appropriate usage of group therapy, and the preferred or optimal size of the group based on the needs of the patients for their particular condition and complexity, not based on an unsubstantiated arbitrary policy.

The proposed allocation of therapy minutes based on a 4-person group establishes perverse incentives. It fails to recognize increased costs associated with providing group therapy in 4-person groups and inappropriately and significantly disincentivizes the provision of therapy in 2- and 3- person groups, despite the evidence that such therapy is beneficial and often preferred to 4-person group therapy. CMS should examine alternatives that both meet it's desire to address the over incentive in the payment system to provide group therapy, without negatively impacting beneficiary functional outcomes and penalizing SNFs that provide group therapy services. Other less restrictive and punishing alternatives are worth considering.

Provision of therapy services in a group session requires more resources than in an individual session. In addition to a greater level of professional skill by the treating therapist to manage and treat patients in a group session, the provision of group services is more expensive. There are individual documentation requirements for each patient, additional coordination and planning required for group treatment, evaluation of multiple patients, and additional communication needs with the interdisciplinary rehabilitation team, physicians, family, etc. If CMS implements its 4-person allocation of therapy minutes, CMS will disincentivize group therapy despite its benefits to the patient as part of their treatment plan.

Option 1: Adjust Limits On Group Time

CMS should first examine the appropriateness of the present cap on group therapy minutes. Currently, group therapy services are limited to a maximum of 25 percent of total therapy minutes by discipline. This helps ensure that group therapy is not a substitute for individual therapy, but rather an adjunct to it. If CMS is concerned about possible over-utilization of group therapy services, CMS could adjust the cap to a level it believes to be more appropriate. In adjusting the cap, CMS should however keep in mind that the cap represents the high-end limit of allowed group therapy for a particular Medicare beneficiary, and not an average or target for allowed group therapy utilization. This approach offers an administratively simple method for addressing the alleged increase in group therapy minutes.

Option 2: Allocate Based On Actual Group Size And Incentivize Provision Of Group Therapy

If CMS wishes to proceed with allocating group therapy minutes, CMS should allocate minutes based on actual group size. Such an approach would not unduly penalize SNFs for providing services in 2- and 3- person groups, and not inappropriately over-incentivize 4-person group. Such an approach, however, does not recognize the additional burdens and costs associated with the provision of group services, nor the difficulty providers and therapists would have in tracking the number of people in a group at all times and accurately counting minutes when patients are dropping in and dropping out throughout a session. Consequently, providers and therapists will have less of an incentive to provide group therapy in situations where the beneficiary therapy needs could be equally met through individual or concurrently provided therapy. If CMS proceeds with the allocation of group therapy minutes, it should modify the SNF PPS to eliminate or mitigate the disincentive for group therapy it will have introduced, and explore some means for recognizing and reimbursing providers and therapists for the increased burden and cost associated with providing group therapy services.

Despite its advantages over the current proposal, this option is currently difficult to operationalize in practice. For a group therapy session in a SNF, it isn't just a matter of all patients showing up, and starting and ending a session at the same time, such as for an aerobics class at one's local gym. Patients drop in and drop out of a group therapy for a number of reasons throughout a session including bathroom breaks, fatigue, illness, appointments, visitors, clinical reasons, non-clinical reasons, etc. Tracking the number of people in a group at all times when patients are dropping in and dropping out throughout a session would be challenging at present. Were CMS to adopt this policy however, technology offers the opportunity to track patient participation in group therapy sessions, albeit with increased provider burden and cost, which CMS should recognize.

Option 3: Allocate Based On Average Group Size (Interim Solution)

In the interim, CMS should consider adjusting group therapy minutes based on the current average size of a group therapy group, rather than an arbitrary cap based on the maximum

number of patients established by Medicare payment policy. This option would pay providers "fairly" for therapy provided to 3-person groups, penalizes providers for providing therapy in 2-person groups, and encourages providers to provide therapy in 4-person groups and reflect the additional burden and costs associated with the provision of therapy services to more than one person at a time. This option is also less administratively burdensome, as providers would not need to track minutes of group therapy based on group size. We encourage CMS to undertake research to determine that average group size so as to be able to appropriately and fairly adjust group therapy minutes in the calculation of total minutes for rehabilitation RUG assignment.

D. Group Therapy Adjustments Should Be Implemented In A Budget Neutral Manner

While AHCA members have a clear preference for implementing adjustments to group therapy that maintain flexibility and "fairly" reimburse for therapy services without unduly increasing the cost of providing therapy services, the key issue for AHCA and its members is that any adjustments to group therapy should be implemented in a budget neutral manner. Changes to group therapy, like the replacement of section T and the allocation of concurrent therapy minutes under RUG-IV, are intrinsic to the SNF PPS. These and other proposed changes will impact case-mix, the integrity of the payment system, and the stability and financial viability of the SNF sector. As with other RUG-IV changes in the proposed rule, any adjustments to group therapy should be implemented in a budget neutral manner.

X. Group Therapy Documentation

(Comments on Section V.C: Group Therapy and Therapy Documentation)

AHCA Recommendations on Changes to Group Therapy Documentation Requirements:

- *CMS should apply therapy documentation requirements to skilled nursing facilities using only SNF laws and regulations*

CMS offers clarification regarding expectations on the clinical documentation needed to support each patient's plan of care related to therapy and group services. CMS has not specifically asked for comments on their recommendations for documentation but we believe CMS has overstated the requirements and has incorrectly justified their position by citing hospital regulation.

The proposed rule states that SNFs are "currently required to prescribe the type amount, frequency, and duration of physical therapy, occupational therapy, and speech-language pathology services in a patient's plan of care. SNF's do not prescribe therapy, but they provide services based on the physician's prescription. The SNF regulation at 42 CFR 483.45 – Special Rehabilitative Services, addresses the provision of services and the resident's comprehensive plan of care, and states that the facility must provide the required services or obtain the required services from an outside resource, in accordance with 42 CFR 483.75(h), from a provider of specialized rehabilitative services. The regulation also states that the specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

The proposed rule attempts to justify requirements for what appears to be additional medical record documentation in order for SNFs to verify that the plan of care is being followed. AHCA is confused by the reference at 42 CFR 409.23(c) and requirements at 42 CFR 409.17(b) through (d). Both regulations are from the State Operations Manual (SOM) Hospital Appendix A and pertain to hospital insurance benefits and benefit exclusions. The hospital regulation may be pertinent to Critical Access Hospitals, Rehabilitation Hospitals, and hospital-based SNFs but does not directly apply to non-hospital owned and operated SNFs.

An issue complicating the use of the Hospital SOM, Appendix A, to justify SNF therapy service documentation requirements, is the May 13, 2011 CMS memorandum to State Survey Agency Directors regarding the SOM - Hospital Appendix A Update. The update addresses the provision of care and personnel qualification and states these must meet national acceptable standards of practice and the requirements of 42 CFR 409.17. The update also offers Interpretive Guidelines for the establishment of the plan of care; the content of the plan in that it must contain the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals; and that any changes to the plan are implemented in accordance with hospital policy and procedures. Again, the cited regulations are for hospitals and there is no indication that these regulations also apply to non-hospital affiliated SNFs. AHCA is concerned with CMS referencing interpretative guidelines to support recommended documentation requirements since interpretive guidance is designed to only assist surveys and providers but is not to be used as a regulatory requirement. Our concern is reinforced by the 2008 memo to State Survey Directors

where CMS reiterates that surveyors must cite all deficiencies based only on violations of statutory and/or regulatory requirements.[28]

The proposed rule addresses the MDS 3.0 resident assessment instrument (RAI) Manual, Section 0400, Therapies, that discusses the following: 1) rationale for therapy coding on the MDS planning for care, 2) offers tips, 3) addresses the use of therapy students, 4) modes of therapy, 5) therapy modalities, and 6) coding examples. Under this manual section, Planning for Care, RAI Manual, page O-14, clinicians are to code only medically necessary therapies that occur after admission/readmission to the nursing home, must provide documentation in the resident's medical plan of care and periodically evaluated the plan to ensure the resident receives the needed therapy, and that the treatment plan is effective. While AHCA concurs that documentation supporting the current therapy plan and services is needed, we find the discussion lacking with regard to identifying significant changes in the patient's medical condition. We believe that regular medical record documentation by all clinicians providing care is a standard of professional practice, and the identification of any significant changes in the patient's medical condition requires timely collaboration among the care team and not just relegated to review of medical record documentation. In addition, therapy care plan goals and changes do not always indicate a change in condition that requires an assessment or relates to any missed therapy days. We appreciate CMS' desire to have adequate documentation so that contractors can verify medical necessity when they review SNF claims. However, clinical documentation of daily care and the methods by which clinicians identify significant changes in condition are not synonymous. Condition changes are noted by Change in Condition assessments and major and minor changes will be noted in the medical record entry, but they are not necessarily repeated in the therapist's note. Clarification is needed on whether CMS is recommending the duplication of condition change documentation in therapy records.

The proposed rule cites 42 CFR 409.17(c)(2) in that SNFs must indicate "the diagnosis and anticipated goals" associated with the therapy services prescribed in accordance with 42 CFR 409.17(c)(1). Again, we remind CMS that the cited regulations apply to hospitals, not SNFs. The OBRA regulation 42 CFR 483.45, Specialized Rehabilitation Services, states under (a) Provision of Services, "If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitation services for the mental illness and mental retardation, are required in the resident's comprehensive plan of care., the facility must –

> (1) Provide the required services; or
> (2) Obtain the required services from an outside resource (in accordance with 42 CFR 483.75(h) of this part) from a provider of specialized rehabilitative services.

Unlike 42 CFR 409.17(c)(1), the OBRA regulation does not mandate additional documentation related to the diagnosis, how therapy services contribute to the patient's anticipated progression toward the prescribed goals, and particularly how the group therapy plan needs to include explicit justification in the plan of care for the use of group therapy. In addition, the RAI Manual, Section O, Therapies, does not mandate that SNFs indicate the diagnosis and anticipated

[28] http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter08-10.pdf

goals associated with therapy for medical record documentation and plan of care. While good documentation is always a desired outcome, we believe CMS' recommendations exceed current law and regulation for SNF care, erroneously correlates hospital regulation, and inappropriately interprets the meaning of Interpretive Guidance.

CMS also contends that the recommended documentation is necessary to demonstrate that the SNF is providing services to attain or maintain the highest practicable, mental, and psychosocial well-being of each resident in accordance with Section 1819(b)(2) of the Social Security Act. However, Section 1819(b)(2) states the SNF must provide the services in accordance with a written plan of care that (A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met; (B) the plan be prepared with participation by the resident, resident's family and the care team; and (C) is periodically reviewed and revised after each assessment. The Act requires a comprehensive assessment which describes the resident's capabilities, is based on a uniform minimum data set, and the use of an instrument that includes identification of medical problems. There is no specific language in Section 1819(b)(2) of the Social Security law that addressed the content of therapy service documentation.

We believe that CMS is broadening the documentation requirements to justify the recommended group therapy change and to accommodate the needs of claims reviewers and in doing so, is exceeding nursing home law and regulation with regard to documentation and plan or care requirements. We recommend that CMS clarify therapy and group therapy documentation requirements using only SNF law and regulation.

XI. End of Therapy OMRAs

(Comments on Section V.D: Proposed Changes to Other Medicare Required Assessments)

AHCA Recommendations on Changes to the Assessment Reference Date Window for End-of-Therapy (EOT) OMRAs:

- *CMS should expand the EOT OMRA ARD window to four calendar days*

With the implementation of RUG-IV, CMS introduced the End-of-Therapy (EOT) OMRA into the SNF PPS. An EOT OMRA was to be completed 1 to 3 days after the discontinuation of all therapies. With the FY 2012 SNF PPS proposed rule, CMS clarified that an EOT OMRA must be completed within 1 to 3 days after the discontinuation of all therapy services for three days, regardless of the reason for the discontinuation and irrespective of whether the facility provides therapy services 5-days or 7-days per week. While CMS' proposal goes a ways toward resolving issues with the selection of the ARD for an EOT OMRA, it does not take into consideration a fundamental problem with the EOT OMRA – namely many SNFs provide therapy 5 days per week and SNF residents occasionally miss a day of therapy for a variety of reasons including holidays, patient illness, Doctor's appointments, etc..

Fortunately, a simple modification to the EOT ARD window could easily resolve this issue. Expanding the EOT OMRA assessment window to four calendar days rather than the somewhat arbitrarily chosen three days would resolve the issue with breaks in therapy involving weekends. Feedback from AHCA and NASL member organizations suggest that about 65 percent of the EOT OMRAs were prompted by one time patient issues that occurred on a Friday or Monday, primarily in SNFs that provide therapy 5-days per week. Extension of the EOT OMRA ARD to up to four calendar days would avoid the filing of numerous unnecessary EOT OMRAs and EOT – resumption (EOT-R) OMRAs and eliminate the need for additional therapist EOT-R OMRA related evaluations – the minutes for which are not reportable or reimbursable on the MDS. AHCA urges CMS to expand the EOT OMRA ARD window to four days.

XII. Change of Therapy OMRAs

(Comments on Section V.D: Proposed Changes to Other Medicare Required Assessments)

AHCA Recommendations on the Introduction and Implementation of Change of Therapy (COT) OMRAs:

- *CMS should reexamine whether existing or other less-burdensome alternative options are available and sufficient to address perceived issues with facility practices in the provision of therapy services;*
- *If CMS proceeds with the COT OMRA, CMS should allow flexibility in the choice of the assessment reference date of the COT OMRA;*
- *If CMS proceeds with the COT OMRA, CMS should not require a COT OMRA during the first 30 days of a patient's SNF stay; and*
- *Any implementation of the COT OMRA, as well as SNF PPS RUG system changes related to EOT OMRAs, EOT-R OMRAs, ARD windows and grace days, student supervision, among others in the proposed rule should be undertaken in a budget neutral manner.*

A. Background

In the proposed rule, CMS introduces a new assessment, the Change of Therapy Other Medicare Required Assessment (COT OMRA). Under CMS' proposal, SNFs would need to evaluate the amount of therapy delivered and the level of therapy for rehab RUG classification on a weekly basis (every 7 days). A COT OMRA would be required whenever the amount of therapy provided to a Medicare beneficiary changed to such a degree that that the patient wouldn't remain classified into the RUG-IV group on the most recent Medicare assessment. CMS is proposing to introduce the COT OMRA because of information that "therapy services recorded on a given PPS assessment did not provide an accurate account of the therapy provided to a given resident outside the observation used for the most recent assignment". CMS further notes that "in some cases, changes in therapy utilization levels may even be unrelated to the patient's clinical condition but may be caused by staffing constraints or facility practices".

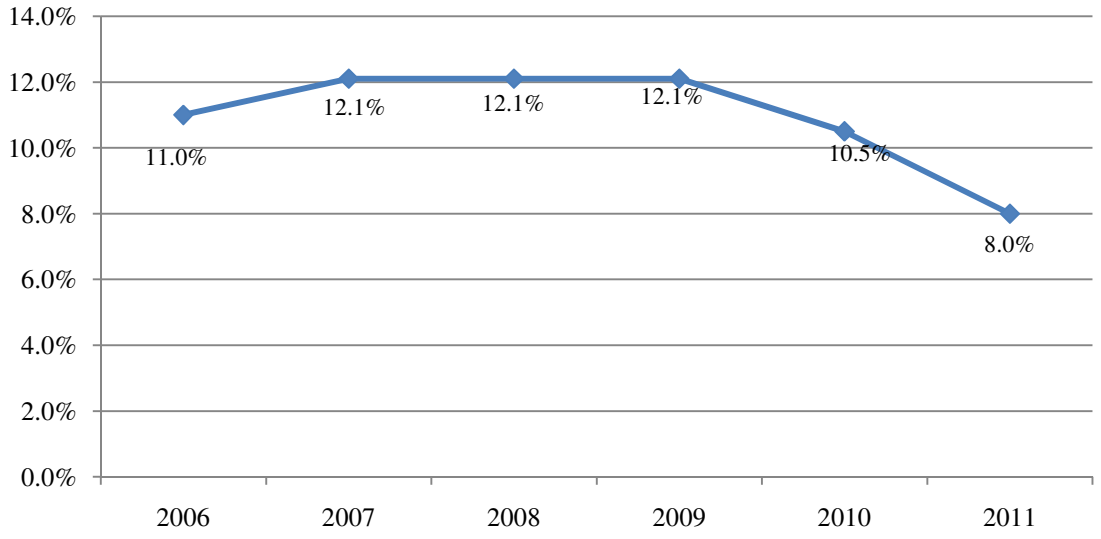
AHCA understands and is supportive CMS' desire to have payment under the SNF PPS reflect services provided to Medicare beneficiaries. As proposed, the desire is somewhat at odds with the goals of a prospective payment system, but given the design of the SNF PPS and how therapy is paid under it, we understand CMS' concerns.

B. Alternative To COT OMRAs

While AHCA understands CMS' concerns and the issues, AHCA is unclear as to how big of an issue this is for the Medicare program, and whether the proposed solution justifies the related administrative burden on SNFs. If the issue were widespread, particularly as it related to SNF or therapy provider practices, we presume that RACs, MACs, and CMS surveyors (See Figure 3)

would be scrutinizing provider behavior very closely. Yet, in reviewing survey citations over time, and reviewing RAC and MAC SNF focus issues, we do not readily see any indication that this is a problem, much less that it is a widespread issue that needs addressing through payment policy and increases provider burdens.

Figure 6: Citations for Accuracy of Assessment (Tag F278)



Source: CMS OSCAR/CASPER Data, Nursing Facility Standard Health Surveys, June of each year
American Health Care Association - Research Department

The burden on providers for monitoring for and filing COT OMRAs is significant. CMS estimates the extra reporting, coding and transmission requirements for COT OMRAs require about one million hours of staff time at a cost of over $32 million annually. The staff time and cost estimates do not include the time and cost involved in collecting and evaluating the information necessary to determine whether a COT OMRA is required. Assuming three COT OMRA related evaluations during a 30 day stay, and the cost is likely well over $100 million annually. The staff resource and cost issues are further compounded by the opportunity cost related to the COT OMRAs.

With overall margins near one percent, coupled with increased costs for proposed changes to group therapy, assessment reference dates and now COT OMRAs, SNF providers will be challenged to absorb these additional increases in operating costs. AHCA is concerned that quality could suffer as SNFs divert nursing and other direct care staff resources away from patient care in order to do paperwork. We encourage CMS to evaluate alternatives to the COT OMRA that do force SNFs to do unnecessary paperwork over meeting the nursing and

rehabilitative needs of the Medicare beneficiaries that we serve. The proposal to introduce the COT OMRA significantly adds to the burden of MDS Coordinators and the need for new evaluations on the part of all therapists. Before proceeding, CMS should reexamine whether existing or other less-burdensome alternative options are available and sufficient to address perceived issues with facility practices in the provision of therapy services.

C. COT OMRA: Flexibility In Choice Of ARD Is Needed To Prevent False Positives

The focus of the COT OMRA, if it is to be implemented, should be on CMS' concerns about inappropriate provider and therapy company practices. The proposed implementation of the COT OMRA however is too inflexible. The COT OMRA, as proposed, will significantly penalize SNFs for one-time resident-specific issues that are outside of the facility's control. In implementing the COT OMRA, CMS should allow SNFs to have the flexibility to make up therapy that was missed due to patient refusal, transient issues, or planned breaks in care.

The COT OMRA, as proposed, will significantly penalize SNFs for one-time resident-specific issues that are outside of the facility's control. Suppose, for example, a resident's plan of care called for the resident to receive an ultra high level of therapy over a week. Let us suppose that the resident was on track to receive 730 minutes of therapy over a 5-day workweek, and the ARD fell on a Wednesday. If the resident didn't feel well on the COT OMRA Wednesday assessment day such that they received only 15 minutes of therapy rather than 45 minutes of therapy that day, a COT OMRA would need to be completed reflecting only 700 minutes of therapy and dropping payment for that resident from an ultra high rehab RUG to a vary high rehab RUG. Alternatively, if the same resident missed therapy on the COT OMRA Wednesday assessment day completely because of a Doctor's appointment or because of the flu for example, a COT OMRA would need to be completed reflecting only 685 minutes of therapy over 4 therapy days, and dropping the payment for that resident from an ultra high rehab RUG to a medium rehab RUG. Typically, if minutes are missed one day, they could be and would typically be made up during a subsequent session. The COT OMRA as proposed does not allow the therapist flexibility to make up for the missed minutes or days of therapy services. In devising the COT OMRA, we presume CMS was seeking to address inappropriate provider behavior, and be punitive toward providers for minor variations between planned and delivered rehabilitation services due to one-time resident-specific issues.

In order to distinguish between inappropriate provider practices and one-time resident-specific issues, we ask CMS to modify the COT OMRA to allow for flexibility in the choice of assessment reference date or allow for grace days at the beginning and end of the 7-day COT OMRA ARD window as is the case with other Medicare required assessments. AHCA offers its assistance and expertise in helping CMS to determine the appropriate ARD window and grace day period for the COT OMRA. Flexibility in the choice of ARD will allow CMS payment policy to not unduly penalize SNFs for one-time resident-specific issues that are beyond their control or in the best interest of the resident, while meeting CMS' concerns about inappropriate practices.

D. COT OMRA: Post 30 Day Assessment Only

CMS proposes that a facility evaluate and file a COT OMRA every seven days after a Medicare-required assessment or EOT-R OMRA. The first 30 days of a rehab patient's stay in a SNF is marked by frequent observation, intensive therapy intervention, and numerous required Medicare assessments. For example, under the current proposal, a facility would complete a 5-day assessment (for simplicity, let us presume it falls on day 5), have to evaluate the need for a COT OMRA on day 12, and then complete a 14-day assessment (again let us presume it falls on day 14). In this example, two days separate the evaluation for a COT OMRA and the regular 14-day assessment. Similarly, under the same assumptions, 2 days would separate the evaluation for a COT OMRA on day 28 and the regular 30-day assessment. Completion of COT OMRAs during the first 30-days of a SNF stay is excessive and duplicative, particularly given that there does not appear to be a widespread issue that could be addressed by other means. Since it would be excessive and duplicative to evaluate and if necessary complete a COT OMRA in the first 30-days of a SNF stay, AHCA recommends that CMS not require that a COT OMRA be completed during the first 30 days of a patient's SNF stay.

E. AHCA And COT OMRAs

The proposed implementation of the COT OMRA does not appear necessary. Available information from RACs, MACs, and CMS, do not appear to show a widespread issue. CMS should reexamine whether existing or other less-burdensome alternative options are available and sufficient to address perceived issues with facility practices in the provision of therapy services. If CMS proceeds with implementation of the COT OMRA, CMS should allow flexibility in the choice of the ARD to not unduly penalize providers for reasons that are beyond the SNF's control and not require that a COT OMRA be completed during the first 30 days of a patient's SNF stay. As with other RUG-IV changes in the proposed rule, SNF PPS RUG changes related to the COT OMRA as well as other EOT and EOT-R OMRA related changes should be implemented in a budget neutral manner. AHCA is interested in working with CMS to help address and resolve this issue.

XIII. Assessment Reference Date And Grace Day Changes

(Comments on Section V.D: Proposed Changes to the MDS 3.0 Assessment Schedule)

AHCA Recommendations on Changes to ARD Windows and Grace Days:

- *CMS should first conduct an analysis before imposing the proposed assessment schedule changes*

CMS is soliciting comments on the proposed changes to the current MDS 3.0 assessment schedule based on the belief that the current grace days and observation periods could cause MDS assessments to be performed in such a way that results in duplicative information being recorded on consecutive assessments. AHCA agrees that the current PPS assessment with the addition of the new MDS 3.0 OMRA assessments leads to duplicative information being recorded. On May 5, 2010, before the implementation of MDS 3.0, AHCA sent comments to CMS identifying our concerns with the application of the required new unscheduled assessments on the PPS assessment schedule and identified issues with redundancy related to the patient interviews. We commend CMS for recognizing that once MDS 3.0 was implemented, information was duplicative of the previous assessment and the frequency of asking the interview questions raised concerns expressed by care staff as well as patients. However, we do not believe the recommended adjustments to the assessment reference dates solve the problems with redundancy and burden and we recommend that CMS first conduct an analysis to determine the efficacy of the recommended changes.

Since the number of unscheduled assessments has increased with MDS 3.0 and more and more short-stay patients are receiving rehabilitative services in SNFs, AHCA believes the proposed modification to the assessment reference date window as well as the assessment reference date grace days for the scheduled PPS assessments will not have the desired impact of reducing duplication of information. It is also unclear how the proposed modifications will impact patient interviews. MDS, Section D0200, asks the patient to self report mood responses in the past two weeks. The RAI manual instructions require the interview to be conducted "the day before or the day of the ARD." This requirement sets additional limits on the time for conducting the assessment; either all the elements are complete on one of these days or the clinician will have to keep going back and forth for each patient. This adds additional time to each assessment. The proposed changes to the assessment schedule will not improve this situation.

Evidence exists that the interview for depression, PHQ-9, is valid when the interview, as designed, is conducted every two weeks.[29] Since the implementation of MDS 3.0 and for most of the PPS patient population, the interview is now being conducted more often than every two weeks. This situation has prompted patient and provider complaints. The proposed assessment schedule modifications do little to extend the period between assessments to two weeks and where the PHQ-9 responses have been validated in study.

[29] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268

AHCA recommends that CMS first conduct an analysis before imposing the assessment schedule recommended changes. The analysis needs to consider all PPS schedule assessments, including the unscheduled assessments (OMRAs), before CMS can fully determine if the proposed changes reduce duplicative assessment information, if provider burden is increase, and if the time between patient interviews is extended enough to eliminate additional concern about the validity of interview information. As with other RUG-IV changes in the proposed rule, changes to the ARD window and grace days should be implemented in a budget neutral manner.

XIV. Therapy Student Supervision

(Comments on Section V.B: Other Issues: Therapy Student Supervision)

AHCA Recommendations on Therapy Student Supervision:

- *CMS should eliminate the line-of-sight requirement for a supervising therapist in situations where a student therapist is prepared to provider rehabilitation services independently without direct therapist supervision;*
- *CMS should allow the time associated with rehabilitation services provided by a prepared independently operating student therapist to be counted fully as skilled therapy minutes on the MDS; and*
- *CMS should allow therapist time to be counted fully as skilled therapy minutes on the MDS when not supervising a prepared and independently operating student therapist, whether the student therapist is in or not in the line-of-sight of the therapist*

AHCA is supportive of the CMS proposal to eliminate the requirement that an adequately prepared therapy student must be in the supervising therapist's line of sight. AHCA would like to request clarification from CMS, however, on whether the SNF could bill for individual therapy provided to a SNF patient by a therapy student operating independently from the therapist, whether in the line-of-sight of the supervising therapist or not. AHCA believes that if the student therapist is adequately prepared to provide individual treatment without line-of-sight supervision by the therapist, then the services provided by the student therapist should be recordable as individual treatment. AHCA also believes that the services provided by the student therapist who does not require therapist supervision should be fully countable as skilled therapy minutes on the MDS irrespective of whether the supervising therapist is in the line-of-sight of the student therapist or not. Similarly, therapy provided by a therapist should be fully counted as skilled therapy minutes when the therapist is not supervising the student therapist. Lastly, as with other MDS 3.0 and RUG-IV changes in the proposed rule, the inclusion of student therapist time on the MDS should be implemented in a budget neutral manner.

XV. Consolidated Billing

(Comments on SectionVII: Consolidated Billing)

AHCA Recommendations on Consolidated Billing:

- *AHCA requests that CMS exclude from the Part A bundle high cost and low probability cytotoxic chemotherapy drugs recommended for exclusion by AHCA;*
- *We ask CMS to support the highest quality cancer treatment for Medicare beneficiaries; exclude high cost and low probability drugs that are used in the treatment of cancer including antineoplastic antiemetics, and supportive medications;*
- *CMS should remove the medical treatment, hyperbaric oxygen therapy, from the SNF Part A bundle; and*
- *CMS should examine current medical practice and modify its policy of permitting certain services to be excluded from the SNF PPS only if provided in a hospital; CMS should permit these same services to be excluded if they are provided suitably and appropriately in sites other than hospitals, chiefly in freestanding clinics.*

A. Background

In this section, we respond to CMS request for comment and re-visit the concept of consolidated billing itself. And we essentially ask CMS to do the same. For one, we ask that CMS reassess its interpretation of various perceived limitations on the Secretary's authority regarding various aspects of consolidated billing. We believe that the health care environment and the public face of CMS has changed dramatically over the last couple of years as the concept of patient-centered care found its way into health care reform legislation. We applaud this development and support CMS efforts.

In preparing for and enabling innovative health care models called for by the Affordable Care Act, it is self-evident that CMS should first eliminate barriers to innovation. We advise that the agency scour its vast array of payment regulations and guidance that inappropriately drive cover of health care services in all of the various providers sectors. Accountable Care Organizations (ACOs), bundling models, dual eligible care integratino models all call for care and care transitions that are patient-centered. A rule refusing Medicare payment for a MRI (magnetic resonance imaging) because a SNF brought a patient to a close, safe and efficient freestanding MRI facility available instead of a distant hospital cannot be thought of as patient-centered.

Below, we address chemotherapy, cancer treatment drugs, hyperbaric therapy, and the CMS site of service billing rule. We ask CMS in reading our comments to consider the principles of health care reform propounded in the ACA and help SNFs to prepare for reform.

B. Chemotherapy

In the proposed rule, CMS invites public comment in identifying codes for further exclusions from PPS consolidated billing of services within four categories specified by Section 103 of the Balanced Budget Refinement Act (BBRA): chemotherapy items, chemotherapy administration services, radioisotope services, and customized prosthetic devices. CMS also believes that, given the related report language of

the BBRA legislation, the services must be characterized by high cost and low probability in the SNF setting and must represent recent medical advances.

CMS has asked in past SNF PPS update proposed rules for exclusion recommendations, and AHCA has consistently responded. However, CMS has taken the position that it does not have the statutory authority to exclude many of the recommended services such as antineoplastic antiemetics and supportive medications used in the treatment of cancer.

In 1999, Congress in Section 103 of the BBRA,[30] excluded from the SNF PPS numerous chemotherapeutic items, as identified by their respective "J Codes," as well as numerous chemotherapy administration services, also as identified by their respective HCPCS codes.

The BBRA provided the Secretary no guidance in expanding the list of items or services to be excluded in the future from the PPS. The Conference Report accompanying the legislation, however, noted that the specific chemotherapy items were excluded from PPS because "these drugs are not typically administered in a SNF, or are exceptionally expensive, or are given as infusions, thus requiring special staff expertise to administer." H. Conf. Rep. 479, 106th Cong., 1st Sess. 854 (1999).

Congress also explicitly recognized that items "may have been inadvertently excluded from the [exclusion] list[,]" (H.R. Conf. Rep. 479, 106 Cong., 1st Sess. 854 (1999)) and therefore, BBRA authorized the Secretary to identify "any additional chemotherapy items" and "any additional chemotherapy administration services" to be excluded from PPS. BBRA § 103(a)(2), amending the Act by adding new paragraphs at 1888(e)(2)(A)(iii)(I) and (II), codified at 42 U.S.C. § 1395yy(e)(2)(A)(iii)(I) and (II).

In a subsequent rulemaking, the Secretary, building on the report language, indicated that items or services that were of the same type as described in one of the four categories in Section 103, including chemotherapy and chemotherapy services, could qualify for exclusion from SNF PPS if (i) "they also meet the same standards of high cost and [ii] low probability [of being used] in the SNF setting." 70 Federal Register 29098 quoting 65 Federal Register 46791.

However, CMS did not recognize that the BBRA authorized the Secretary to identify "any additional chemotherapy items" and "any additional chemotherapy administration services" to be excluded from PPS in the event that items . "may have been inadvertently excluded from the [exclusion] list." Thus, CMS requires that chemotherapy drugs recommended for exclusion had to have come on the market after April 20, 2000.

We disagree with CMS' statutory interpretation regarding the lack of eligibility for exclusion of drugs that were on the market in April of 2000 but not excluded by Congress. We believe that Congress did "inadvertently exclude" several very expensive drugs which the Secretary has the authority to exclude. However, within the context of CMS' interpretation and request for public comment in identifying codes for further exclusions from PPS consolidated billing of services within four categories specified by Section 103 of the BBRA, we provide the recommendations below that we believe meet all current CMS criteria.

[30] Pub. L. 106-113.

1. Chemotherapy Agents

We recommend that CMS add the following chemotherapy drugs to the excluded chemotherapy list. Where we can, we identify the drug by code. These are "traditional" cytotoxic chemotherapies that meet the criteria for high cost and low probability. In addition, they came on to the market after April 2000, the year of Congress' action. Thus, they meet all of CMS' criteria for exclusion. We ask that CMS address these individual drug exclusion recommendations in the final rule and specify the reason for exclusion or non-exclusion.

Chemotherapy Drugs Proposed for Exclusion

Brand Name	Generic Name	HCPCS	Date Available	ASP
Afinitor	Everolimus	G0290	3/30/2009	*
Anastrozole	Arimidex	J3490	*	*
Bicalutamide	Casodex	J3490	*	*
Dacogen	Decitabine	J0894	5/2/2006	$28.03
Estramustine	Emcyt	J3490	*	*
Fulvestrant	Faslodex	J3490	*	*
Gleevec 400mg	Imatinib	*	5/10/2001	$150.71/dose
Iressa 250 mg	Gefitinib	J8565	5/5/2003	$70.91 / dose
Letrozole	Femara	J3490	*	*
Nexavar 200 mg	Sorafenib	*	*	$58.68 / dose
Sprycel 100 mg	Dasatinib	*	6/28/2006	$250.93 / dose
Supprelin LA	Supprelin LA (Histrelin)	J9226	*	*
Sutent 50 mg	Sunitinib	J3490	1/26/2006	$318.20 / dose
Tarceva 150 mg	Erlotinib	J3490	*	$151.89/ dose
Tasigna 200 mg	Nilotinib	*	*	$70.36/ dose
Trelstar Depot/LA	Triptorelin	J3315	6/15/2000	$163.96
Tykerb 250 mg	Lapatinib	*	3/13/3007	$$26.09/dose
Zolinza	Vorinostate	*	10/9/2006	$82.53 / dose

* Information not available

2. Additional Cancer Treatment Drugs -- Antineoplastic Antiemetics And Supportive Medications

CMS interprets the BBRA to prohibit it from:

> (1) excluding antineoplastic antiemetics and supportive medications which while not chemotherapeutic agents in themselves are necessary to the treatment of cancer, and
>
> (2) excluding chemotherapy drugs that were in existence at the time of the effective date, April 1, 2000,[31] of Section 103 of the BBRA but not excluded by Congress.

[31] The amendments made by the section shall apply to payments made for items furnished on or after April 1, 2000.

CMS' interpretation of the statute results not only in CMS' inability to exclude certain traditional chemotherapy drugs that have cytotoxic properties but were in existence in April of 2000 but also in its inability to exclude other critical categories of drugs important in the treatment of cancer. These other drugs include antineoplastics which are new chemotherapeutic agents which are not cytotoxic but target cancer cells at various stages of reproduction and proliferation. They also include drugs that are traditionally used in combination with chemotherapy, such as antiemetics and supportive care drugs.

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

To exclude chemotherapy from consolidated billing without excluding the drugs and biologicals needed in conjunction with this treatment is to place a financial burden on SNFs, as their costs far exceed the payment received under the PPS. Additionally, hospital outpatient departments are paid extra for these drugs and biologicals, since many are given a separate ambulatory payment classification (APC). In essence, these drugs and biologicals are unbundled for hospitals, but bundled for SNFs. These drugs are administered by injection: intravenously, intramuscularly or subcutaneously.

We ask CMS to support the highest quality cancer treatment for Medicare beneficiaries by excluding high cost and low probability drugs that are used in the treatment of cancer including antineoplastic antiemetics, and supportive medications. Given CMS' positions on the limitations of its statutory authority, legislation may be needed to provide exclusion and to provide the Secretary with full flexibility to determine exclusions in these areas without any statutory code constraints. If that should prove to be the case, we ask that CMS support SNFs in our efforts to achieve legislation.

C. Hyperbaric Oxygen Therapy

CMS should remove the following HCPCS (Healthcare Common Procedure Coding System) code for hyperbaric oxygen therapy from the list of non-excluded outpatient surgery and related procedures.[32] It meets the criteria of being an intensive invasive procedure that is specific to the hospital setting" and under commonly accepted standards of medical practice lie exclusively within the purview of hospitals rather than SNFs. See 63 Federal Register 26298, May 12, 1998.

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

*CMS indicates that inclusions, rather than exclusions, are provided regarding outpatient surgery and related procedures because of the great number of surgery procedures that are excluded and can only be safely performed in a hospital operating room setting.
** Pricing is based on actual invoices from hospitals for hyperbaric oxygen therapy.

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

Section 4432(b) of the Balanced Budget Act of 1997 (BBA), Pub. L. 106-113, established a consolidated billing requirement that places with the SNF the Medicare billing responsibility for virtually all of the services that the SNF's residents receive, except for a small number of services that the statute specifically identifies as being excluded from this provision. CMS early on recognized that some services that patients could receive while in a SNF Part A stay were outside the scope of SNF services.

These were, according to CMS, "intensive diagnostic or invasive procedures that are specific to the hospital setting." 63 Federal Register 26298, May 12, 1998. CMS determined that these services, "under commonly accepted standards of medical practice lie exclusively within the purview of hospitals rather than SNFs, and thus were "not subject to consolidated billing." Id.

Over time, under this standard, CMS has excluded MRIs, computerized tomography (CT) scans, ambulatory surgery involving the use of an operating room, cardiac catherization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures. However, in order to be excluded from PPS, the services must be provided in a hospital.

Hyberbaric Oxygen (HBO) is a medical treatment in which the patient is entirely enclosed in a pressure chamber breathing 100% oxygen at greater than one atmosphere pressure. It is an intensive invasive procedure that is specific to the hospital setting and under commonly accepted standards of medical practice lie exclusively within the purview of hospitals rather than SNFs. Indeed HBO is generally available in university hospital settings since such hospitals have a tertiary patient population referrals base for this specialized treatment. The procedure without question meets the criteria of beyond the scope of SNF care.

It should be noted that the treatment can cost over $1,500, and treatments can be provided on a daily basis over a number of days. Recently, a provider reported a hospital charge of $11,900 for a daily treatment (at $1700 per treatment) for over 7 days. To the best of our knowledge, given the fact that this procedure was not historically preformed by SNFs, the cost of this procedure, like the cost of MRIs and CT scans is not in the SNF PPS base.

HBO does the following:

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

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

- Preparation and preservation of compromised skin grafts (not for primary management of wounds – excludes artificial skin graft). Preservation of compromised skin grafts utilizes HBO therapy for graft or flap salvage in cases where hypoxia or decreased perfusion has compromised viability. HBO therapy enhances flap survival. Should a graft or flap fail, HBO therapy may be used to prepare the already-compromised recipient site for a new graft of flap. HBO therapy is not covered for the initial preparation of a skin graft site and is not considered medically-necessary for the preservation of normal, uncompromised skin grafts or flaps;

- Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management. Chronic refractory osteomyelitis is an infection in bone that persists or recurs, following appropriate interventions. Such interventions include the use of antibiotics, aspiration of abscess, immobilization of the affected extremity, and surgery. Medicare Part A can cover the use of HBO for chronic refractory osteomyelitis that has been demonstrated to be unresponsive to conventional medical and surgical management;

- Treatment of osteoradionecrosis and soft tissue radionecrosis. HBO is one part of an overall plan of care, along with debridement or resection of nonviable tissues, in conjunction with antibiotic therapy;

- Treatment of soft tissue radionecrosis as an adjunct to conventional treatment; and

- Diabetic wound of the lower extremities in patients who meet the following three indications:

    - Patient has type I or type II diabetes and has a lower extremity wound that is due to diabetes;
    - Patient has a wound classified as Wagner grade III or higher; and
    - Patient has failed an adequate course of standard wound care.

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

HBO is generally available in university hospital settings since such hospitals have a tertiary patient population referrals base for this specialized treatment. Residents can be treated in the SNF setting for their wound therapy and receive HBO as adjunctive therapy, as indicated above.

It is clear that excluding hyperbaric oxygen therapy is squarely within the confines of CMS' current interpretation of its regulatory authority to exclude items and services from the SNF Part A bundle that are beyond the scope of a SNF and within the scope of a hospital.

D. Site of Service Consolidated Billing Rule

As indicated above, CMS has excluded MRIs, CT scans, ambulatory surgery involving the use of an operating room, cardiac catheterization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures. However, in order to be excluded from PPS, the services must be provided in a hospital. If they are provided in a freestanding clinic, such as a radiation therapy clinic or imaging center, they are not excluded.

In 1998, the advent of PPS, CMS was reflecting then current medical practice in its development of the regulatory PPS exclusions. However, medical practice has changed, and the services in question are no longer exclusively within the purview of hospitals. Radiation therapy is now commonly provided in freestanding radiation therapy clinics, and MRIs are available from freestanding entities. Our understanding is that freestanding ambulatory surgery clinics have also been growing.

In addition, some hospitals have subcontracted operation of the imaging and radiation therapy departments that are located within the four walls of the hospital to unaffiliated third party organizations.

This has made it very difficult for SNFs to know whether or not the services being provided to their patients even within the four walls of the hospital are subject to consolidated billing or not.

AHCA has consistently requested that CMS examine current medical practice and modify its policy of permitting certain services to be excluded only if provided in a hospital but not if provided suitably and appropriately in sites other than hospitals, chiefly freestanding clinics. This policy change should be considered, at a minimum, for ambulatory surgery, MRIs, and radiation therapy services.

CMS created its exclusion policy based on two factors:

- That these services (MRIs, CT scans, ambulatory surgery involving the use of an operating room, cardiac catheterization, hospital outpatient radiation therapy, hospital outpatient angiography, and certain lymphatic and venous procedures) that patients could receive while in a SNF Part A stay were outside the scope of SNF services; and,
- That at the time of implementation of the PPS, these were "intensive diagnostic or invasive procedures that [were] specific to the hospital setting." 63 Federal Register 26298, May 12, 1998.

We fully understand that this is a two-pronged test. With regard to the second prong, in the final rule for FY 2006, CMS indicated that the exclusion of certain outpatient hospital services … is targeted specifically at those services…that, under commonly accepted standards of medical practice, lie *exclusively* within the purview of hospitals… that is, services which generally require the intensity of the hospital setting in order to be furnished safely and effectively." 70 Federal Register 45026 at 45049, August 4, 2005.

However, the second prong is in many cases no longer feasible. Certain of these intensive diagnostic or invasive procedures are no longer specific to the hospital setting because of changes in medical practice and technology. Ambulatory surgery, MRIs and radiation therapy services are now being furnished safely and effectively in freestanding clinics. If this is not the case, why is Medicare paying for these freestanding facility services?

It does not follow, however, that if the services are now within the scope of freestanding facilities, that they are within the scope of SNF services. To our knowledge all these exclusions remain beyond the scope of SNF comprehensive care plans. We know of no evolution of SNF care that has enabled SNFs to perform these services. And yet, CMS suggests that if medical technology has improved to the point of performing these services in a less intensive setting such as freestanding facilities, the logical concision would be to cease exclusion and consider these all SNF services. CMS' exact language is as follows:

> Thus, to the extent that advances in medical practice over time may
> make it feasible to perform such a service more widely in a less intensive, nonhospital setting,
> this would not argue in favor of excluding the nonhospital performance of the service from consolidated billing under these regulations,
> but rather, would call into question whether the service should continue to be excluded from consolidated billing at all, even when performed in the hospital setting. Id.

This statement in effect says that while such services are beyond the scope of SNF comprehensive care plans and should be excluded from consolidated billing, since they are now within the scope of freestanding facilities they should be included in SNF consolidated billing -- regardless of the fact that they are not within the scope of SNF care.

In addition, the rule as it now stands has other unintended consequences. Some SNFs continue to have a problem with MRIs and CT scans performed in acute care hospital outpatient departments under contract with independent MRI/CT scan companies. Even though these tests are in the acute hospital outpatient department and would appear to be an excludable item under Medicare PPS consolidated billing, the fact that the services are not being billed by the hospital has caused Medicare Part B to reject the claims as submitted by the contractor, rendering the services bundled back to the SNF.

CMS supports this result relying on the criteria for valid arrangements for services provided to beneficiaries. For the hospital's ''arrangement'' with the other entity to be a valid one, the hospital cannot act merely as a billing conduit, but must actually exercise professional responsibility and control over the arranged-for service. Therefore, in a situation where the other, non-hospital entity assumes the Medicare billing role, a valid arrangement between the hospital and that entity would no longer exist, so that the hospital effectively relinquishes its professional responsibility and control over the service to the other entity. In such circumstances, exclusion is precluded and the SNF is responsible for payment.[33]

We understand CMS' position on valid arrangements. However, we feel that the growing denials based on the lack of a "valid arrangement" underscores the basic flaw that has developed in CMS' insistence on the role of the hospital in exclusion – CMS' refusal to acknowledge medical transformation.

When medical technology marches on, payor coverage normally tries to accommodate. Old less efficacious drugs are replaced by newer more efficacious drugs; old CT technology is replaced by new CT scans. And now, we know how crucial comparative effectiveness research[34] is becoming in our search for what works best and what can truly help in health care reform. While not precisely related to the comparative effectiveness of health care strategies, insisting on service delivery in what might be an outmoded environment for such services runs entirely counter to the spirit of progress, best practices, and health care reform. In this new health reform environment, threatening the loss of SNF PPS exclusions because freestanding facilities can perform MRIs, CT scans, ambulatory surgery and radiation therapy services is unproductive -- and very difficult to understand.

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[33] … [t]his underlying concept of service intensity also affects the manner in which a hospital can involve another entity in the actual performance of an excluded outpatient hospital service. Sections 1832(a)(2)(B) and 1861(s)(2)(C) of the Act authorize a hospital to furnish outpatient diagnostic procedures under arrangements with another entity; moreover, MRIs or CT scans that are furnished in this manner are excluded from SNF consolidated billing, and would be separately billable *by the hospital* under Part B. However, in order for the hospital's ''arrangement'' with the other entity to be a valid one, the hospital cannot act merely as a billing conduit, but must actually exercise professional responsibility and control over the arranged-for service, as specified in the guidelines on arrangements that appear in the CMS Internet-Only Manual, Pub. 100–1, Chapter 5, section 10.3, available online at *ttp://www.cms.hhs.gov/Manuals/IOM/list.asp.* Therefore, in a situation where the other, non-hospital entity assumes the Medicare billing role, a valid arrangement between the hospital and that entity would no longer exist, so that the hospital effectively relinquishes its professional responsibility and control over the service to the other entity. In this situation, because the service is no longer being furnished by the hospital itself—either directly, or under a valid arrangement with another entity—it would not qualify for the administrative exclusion from consolidated billing as a high-intensity outpatient *hospital* service, and the billing responsibility for the service would remain with the SNF.

[34] *What Work in Health Care? What Doesn't?* The Commonwealth Fund, June 18, 2009. http://www.commonwealthfund.org/Content/Newsletters/Purchasing-High-Performance/2009/June-18-2009/Feature-Articles/

XVI. Value-Based Purchasing

(Comments on Section: IV.A: Value-Based Purchasing (Section 3006)

AHCA Recommendations On The Development Of A Plan To Implement A Value Based Purchasing Program (VBP)For SNFs:

- *CMS should delay the report to Congress until it can study and incorporate the results of the SNF VBP demonstration;*
- *CMS should identify or develop measures (outcome measures) that reflect the purpose and goals for post acute care that are appropriate for VBP as currently available MDS measures do not capture the major outcomes and goals of post acute care;*
- *CMS Should Consider and Harmonize SNF Current and Future Quality Related Programs and Collaborative Efforts in Designing a SNF VBP Program;*
- *CMS should not move forward with a specific value-based purchasing plan for skilled nursing centers without validated quality measures that reflect data collected under MDS 3.0, and treatment of the survey issues addressed below;*
- *CMS should evaluate and incorporate lessons learned from Medicaid demonstrations that have a VBP component;*
- *CMS should complete its current rehospitalization studies to better delineate criteria for avoidable and non-avoidable rehospitalizations and to develop adequate risk adjusters;*
- *If CMS plans to use structural measures of quality (e.g. staffing) in a VBP program), CMS should develop staffing measure that accounts for the differences in facilities, consider therapist and physicians in the staffing count, and take into account staff experience;*
- *CMS should incorporate customer and employee satisfaction measures; and*
- *Regarding payment, if budget neutrality is prescribed, CMS should consider an approach that does not punish providers and relies on savings from the reduction of rehospitalization.*

Section 3006(a) of the ACA directs the Secretary to develop a plan to implement a VBP program for SNFs, with a report to Congress due by October 1, 2011. CMS indicates that it is in the process of developing the SNF VBP implementation plan and report. The statute directs CMS to consult with stakeholders in developing the implementation plan, as well as considering the outcomes of any recent demonstration projects related to VBP which it believes might be relevant to the SNF setting.

A. CMS Should Delay The Report To Congress Until It Can Study And Incorporate The Results Of The SNF VBP Demonstration

While AHCA welcomes programs that will enhance quality, and have undertaken our own quality improvement programs, we have recommendations on the report to Congress on VBP due by October 1, 2011. We believe the report will be most helpful if it relies on the results of the Nursing Home Value-Based Purchasing (NHVBP) demonstration.[35] However, the NHVBP

[35] The Nursing Home Value-Based Purchasing (NHVBP) Demonstration is CMS' "pay-for-performance (P4P)" initiative to improve the quality of care furnished to all Medicare beneficiaries in nursing homes. Under this demonstration, CMS provides

demonstration results will not be available until after October 2011. Relying on this demonstration is consistent with Congress's directive that CMS consider the outcomes of any recent demonstration projects related to VBP which it believed might be relevant to the SNF setting. Thus, we recommend that CMS wait to submit the plan to congress.

We believe without question that the outcomes the NHVBP is relevant to the SNF setting since the very goal of the demonstration was to test a VBP in SNFs with, in addition, the reduction of avoidable hospitalizations and rehospitalizations as a key driver of the anticipated savings. Under this demonstration, CMS provides financial incentives to nursing homes that meet certain performance measures established by CMS.

The approach is to assess the performance of nursing homes based on selected quality measures, and then make "performance" payments to those nursing homes that achieve the best performance or the most improvement based on those measures. Performance is assessed in the following four domains: staffing, appropriate hospitalizations, outcome measures from the minimum data set (MDS), and survey deficiencies from state health inspections. The reduction of avoidable hospitalizations is a key driver of the anticipated savings.

The demonstration began July 1, 2009 in Arizona, Wisconsin and New York. The demonstration is scheduled to end June 30, 2012. Thus, the evaluation results are still some time away from being available. Further, AHCA understands that CMS believes that with respect to the demonstration it may take the full three years for the demonstration to realize if there are any savings, i.e., the process of reducing avoidable hospitalizations and rehospitalization may be gradual and CMS may not be able to say, short of three years, if the NHVBP has succeeded in this respect.

AHCA recommends that CMS delay the report to Congress until it can study, refine components if needed, and then incorporate the results of the SNF VBP demonstration.

B. CMS Should Identify Or Develop Measures (Outcome Measures) That Reflect The Purpose And Goals For Post Acute Care That Are Appropriate For VBP As Currently Available MDS Measures Do Not Capture The Major Outcomes And Goals Of Post Acute Care

The goal and purpose of post acute care is to help Medicare beneficiaries achieve their highest level of function, quality of life and return to the most independent level of living or for those with a terminal condition to have as peaceful death as possible. Thus, a VBP program should link reimbursement related to achieving these goals. However, current measures of SNF post acute services do not adequately capture or measure these outcomes.

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financial incentives to nursing homes that meet certain performance measures established by CMS. The approach is to assess the performance of nursing homes based on selected quality measures, and then make "performance" payments to those nursing homes that achieve the best performance or the most improvement based on those measures. Performance is assessed in the following four domains: staffing, appropriate hospitalizations, outcome measures from the minimum data set (MDS), and survey deficiencies from state health inspections.

In addition, we recommend that CMS rely on outcomes measures (rather than process or structural measures of quality) when designing a SNF VBP program. The current CMS NHVBP demonstration begins to evaluate the use of some outcome measures (e.g. rehospitalization, pressure ulcers and changes in Activities in Daily Living) but still does not capture other important outcomes. We recommend that CMS consider additional functional measures (ability and improvement in ambulation), discharge destination (same setting prior to hospitalization) and resident satisfaction. We also recommend that CMS consider using some measures about the quality of the dying experience for those admitted to SNF with terminal conditions or who die during or shortly after their SNF stay.

C. CMS Should Consider And Harmonize SNF Current and Future Quality Related Programs And Collaborative Efforts in Designing A SNF VBP Program

Another reason for a delay in finalizing such a study to be to provide time to study the multiple initiatives related to VBP that are on the horizon that will impact SNFs. These programs that currently address quality and those that will do so in the future call out for some harmonization, e.g., a plan for co-ordination. The multiple initiatives that will impact SNF quality measurement on the drawing broad that CMS should consider in the report include:

- A mandated study for expansion of the existing preventable Hospital Acquired Conditions (HACs) to payment made in various post-acute settings including SNFs, due to Congress no later than January 1, 2012, which must include the impact of expanding the HAC policy on patient care, safety, and overall payments;
- A recently issued final rule for Medicaid Payment for Provider Preventable Conditions pertaining to providers other than hospitals;
- ACO quality measures that participating and contracting SNF providers must support;
- The development of a national, voluntary pilot program on payment bundling by January 1, 2013 required by Section 3023 calling for yet another set of quality measures; [36] and
- MDS 3.0 quality measures that are currently being tested and will not be made available for public review until the spring of 2012.

[36] Providers participating in the pilot are required to submit data to the Secretary on certain quality measures established by the Secretary. At a minimum, these quality measures must include:

- Measures of functional status improvement
- Reduction in avoidable hospital readmissions
- Rates of discharge to the community
- Rates of admission to an emergency room after hospitalization
- Incidence of health care acquired infections
- Efficiency
- Patient-centeredness of care
- Patient perceptions of care
- Other measures determined by the Secretary

In addition to the statutory and regulatory programs indicated above, strong nursing facility quality efforts have been underway for quite some time most notably since 2002 with the onset of the Nursing Home Quality Initiative -- where provider collaboratives were formed to address pain management, pressure ulcer prevention, customer satisfaction and workforce retention. In tandem with the Nursing Home Quality Initiative, the LTPAC provider community launched its own voluntary quality initiative, *Quality First: A Covenant for Healthy, Affordable and Ethical Care.* This initiative brought together 6,000 providers from across the country to make the public commitment to improving quality performance in five key measures including high rates of resident and family satisfaction, increase in employee retention rates, improved quality measures, and improved regulatory compliance.

Quality First paved the way for the landmark Advancing Excellence in America's Nursing Homes Campaign in 2006. This is a model public/private partnership that has improved performance and established a rich learning community across the country. Thirty LTPAC stakeholder organizations including CMS, State Survey and Aging representatives, nursing and physician organizations, labor, and advocates are united in this initiative to improve the performance of nursing homes. Advancing Excellence has eight goals to improve nursing home performance -- staff stability consistent assignment, resident satisfaction, pain management, advance care planning, and the reduction of pressures ulcers and restraints. Today more than 7000 LTPAC providers, 46% of all homes nationwide, are participating in the Campaign.

Another significant quality program is the AHCA/NCAL National Quality Awards program. The program embeds the criteria of the Malcolm Baldrige National Award. The award has three levels bronze, silver and gold. The purpose of the award is to guide LTPAC providers on their quality journey. In 2011, more than 1,000 applications were received.

Thus, we believe that a VBP program will be most effective in achieving the best outcomes for the best price (e.g., value) if CMS takes advantage of demonstration results and considers the plethora of programs discussed here to co-ordinate and integrate or harmonize where possible and avoid redundancy and conflict. CMS should look to the success of past and continuing collaborative quality improvement efforts that have been forged by CMS, states, and providers. Lastly, in developing the study, the agency should take into account the following measurement and payment issues raised by a VBP system.

D. CMS Should Not Move Forward With A Specific VBP Plan For Skilled Nursing Centers Without Validated Quality Measures That Reflect Data Collected Under MDS 3.0, And Treatment Of The Survey Issues Addressed Below

Implementation of MDS 3.0 requires revisions in quality measures. Section 3006 of ACA requires the Secretary to consider the on-going development, selection, and modification process for measures and the reporting collection and validation of quality data. As you know, the nursing home sector has just transitioned from MDS 2.0 to MDS 3.0 and even CMS acknowledges the need to recalibrate its perceived quality measures to reflect the revisions in source data.

In addition, new assessment tool have been developed, but not yet implemented, related to payment for rehabilitation services. Measure testing is needed to ensure that the impact of the new assessments on measurement and the selected items are validated before released for public reporting. Due to assessment tool changes and definitions, the correlation between MDS 2.0 and MDS 3.0 is poor and in some cases non-existent. To move forward with a specific VBP plan for skilled nursing centers at this time and without validated quality measures that reflect data collected under MDS 3.0 would be a mistake.

For the past eight years, AHCA has been at the forefront of efforts to develop SNF quality measures. We have advocated for appropriate and meaningful risk adjusted and validated quality measures and standards, and we have invested resources to advance the science of quality metrics. The implementation of MDS 3.0 offers the profession additional clinical data, which, properly applied, can significantly improve performance measures.

In addition, MDS-based measures do not account for most differences from one assessment to another. The MDS is only a snap shot of the patient's condition for the period of time that assessment takes place. It is not designed to be a diagnostic tool. For example, pain can change over time and be unrelated from one assessment to another, but the MDS does not account for the cause of the pain – only that pain is present. Thus, post-operative pain found on one assessment can be controlled but does not account for occasional arthritic pain and flare-up that is the basis for pain reported on a subsequent evaluation.

Another factor to consider is that there is state-by-state (and possibly team-by-team) variability in the survey process, and Medicare's usual methods of adjusting (if at all) for this variability are rudimentary. Facility to facility differences should be a factor, as some facilities take patients that another facility may not accept because they are too complex.

We recommend that CMS not move forward with a specific VBP plan for skilled nursing centers without first validated quality measures that reflect data collected under MDS 3.0 and treatment of the survey issues presented above.

E. CMS Should Evaluate And Incorporate Lessons Learned From Medicaid Demonstrations That Have A VBP Component

CMS should look at state efforts to pay or not pay for certain quality metrics (e.g. outcomes, process of care or structural measures of quality) to determine how a SNF VBP program can be implemented in the most fair an efficient manner. However, any such analysis must also take into account that the population of patients covered by Medicaid and their goals of care differ from the post acute care population.

Similarly since the Medicaid reimbursement methods also differ from SNF reimbursement methods, these differences likely mean that methods from Medicaid VBP programs cannot be readily transferred "as is" but can help inform any post acute care VBP program.

F. CMS Should Complete Its Current Rehospitalization Studies To Better Delineate Criteria For Avoidable And Non-Avoidable Rehospitalizations And To Develop Adequate Risk Adjusters

The importance of reducing avoidable hospitalizations and rehospitalizations is central to almost every quality effort in every health care provider sector. The need to reduce these hospitalizations cannot be minimized. The hope is that such reduction will improve health care, the health of Medicare beneficiaries and provide Medicare savings.

However, determining what is avoidable is still an issue that has not as yet been adequately and fully addressed yet must be addressed before permitting it to drive a punishment and reward VBP system. Current measurement relies on identification of ambulatory-sensitive conditions that focus on single conditions. This approach falls short when dealing with individuals with multiple chronic conditions that together, impact patient severity and need for hospitalization.

We do not know as yet if the VBP measurement system used in the demonstration recognizes the complexities that SNFs deal with on a daily basis. The issue of rehospitalization is complex. Rehospitalizations can be the result of premature discharge from the hospital or suboptimal care in the acute care institution and by attending physicians. Sicker and quicker discharge is not just a matter of timing but possibly also a matter of quality of treatment. It must be determined if this complexity around a rehospitalization can be picked up in a VBP program.

Rehospitalization also becomes a problem in a "siloed" VBP program that only focused on SNF providers, when the overall functioning of the system is affected by other providers such as physicians and hospitals. Under this approach, SNFs become the de-facto manager of the relationship with the physician and the hospital, while balancing that with the relationship of the patient. This places enormous risk on SNFs.

The sharing of information, or lack thereof, also plays an important role between the various providers along the health care continuum. Not infrequently, the patient arriving on the SNF doorstep is not the patient described by the hospital or otherwise anticipated by the SNF. Sole responsibility for poor, spotty or incomplete information and communication cannot be laid at the feet of the SNF.

Andy Kramer's work should be reviewed as a model in which structures and processes in quality measurement are identifiable and known to produce good outcomes. A good example for this is the nurse practitioner model tested by Mary Naylor.[37] An effective incentive program could be structured to help pay for a nurse practitioner, while maintaining accountability. This approach would be a win-win because it could improve quality outcomes by reducing rehospitalization rates and creating savings.

The bottom line is avoidable hospitalization and rehospitalization, as a measure in a VBP program, must use appropriate risk-adjusters. The reality is that SNFs care for patients with

[37] Naylor M, Brooten D, Jones R, Lavizzo-Mourney R, Mezey M, Pauly M. Comprehensive Discharge Planning for the Hospitalized Elderly. Annals Internal Medicine, 1994, 120:999-1006

multiple comorbidities. This can create substantial differences between individual patients, and the current risk-adjusters being used in this area are weak to non-existing.

AHCA recommends that CMS more deeply study avoidable hospitalizations and rehospitalizations in an effort, among other things, to delineate criteria for avoidable and non-avoidable, and, in addition, that CMS develop adequate risk adjusters.

We also recommend that CMS explore other measurement methodologies to allow more accurate measurement of outcomes across the various provider settings. In an article entitled *Using Population Segmentation to Provide Better Health Care for All: The "Bridges to Health" Model*, the authors Lynn, Straube, Bell, Jencks and Kambic divide the population into eight groups; people in good health, in maternal/infant situations, with an acute illness, with stable chronic conditions, with a serious but stable disability, with failing health near death, with advanced organ system failure, and with long-term frailty.[38] They propose that each group has its own definitions of optimal health and its own priorities among services.

AHCA finds the *Bridges to Health Model* discussion enlightening with regard to its potential use in providing the framework for the next generation of healthcare quality measurements. At least half of the identified population groups are currently found in nursing care facilities. Since each patient needs different services for the attainment of optimal health; building a measurement system based on population segments, not funding approaches, may allow for measures to be used across provider settings and compared. This approach potentially offers a more appropriate method to measure quality for like-patients across care settings, tie payment to quality, and in implementing a bundled or VBP payment system.

G. If CMS Should Plan To Use Structural Measures Of Quality In A VBP Program, CMS Should Develop Staffing Measure That Accounts For The Differences In Facilities, Consider Therapist And Physicians In The Staffing Count, And Take Into Account Staff Experience

While staffing measures are correlated with outcomes, their predictive value for identifying one nursing facility over another for providing superior quality outcomes is poor. Thus, we recommend that CMS focus its efforts on using outcome measures related to the goals and objectives of post acute care rather than structural measures of quality such as staffing.

A staffing measure does not account for differences between facilities. The staffing measure used in 5-Star is an example of a flawed measure resulting in many good facilities receiving 1-star. The measure looks at nursing but does not consider therapy or physicians or physician extenders. There needs to be a consideration of all the caregivers involved, and it should not be just about quantity but skill level appropriateness. Some types of staff can actually increase

[38] Lynn, J., Straube, B., Bell, K., Jencks, S., Kambic, R. Using Population Segmentation to provide Better Health Care for All: The "Bridges to Health" Model. The Milbank Quarterly, Vol. 85(2):185-208 (2007).

quality through efficiency, making the quantity of staff less of a factor. More staffing can be a good thing, in general, but it can sometimes be a misdirection of resources.

Staff experience, individually, and as a member of a cohesive and coordinated unit (consistent assignement), are as important as the number of staff in the facility. Because SNFs cannot pass along the costs of more – and more experienced – staff to Medicare, administrators must make a decision between hiring greater numbers of relatively inexperienced (possibly lower quality) staff and fewer but more experienced (possibly higher quality) staff. Nowhere does 5-Star recognize this important trade off.

We recommend that CMS develop staffing measure that accounts for the differences in facilities, considers therapist and physicians in the staffing count, and takes into account staff experience and consistent assignments.

H. CMS Should Incorporate Customer And Employee Satisfaction Measures

Since the early 1990's AHCA has been a leader in focusing on the voice of the consumer as the driver of results-oriented performance improvement, transparency, and informed decision-making in long term care. To date more than 5,000 AHCA members, and many other long term care providers, are using surveys that are valid and reliable. For example, the My InnerView, 2009 national survey, based on the responses of 233,300 residents and their families, showed that 86% rated their facility as being good to excellent. We strongly recommend that any VBP program would be incomplete and not pass face validity if it does not contain resident satisfaction.

AHCA supports the use of standardized surveys to collect feedback from residents and family members. In 2011 the National Quality Forum recommended the use of CAHPS (Customer Assessment of Health Plans) surveys to gather customer feedback. While AHCA agrees that a standardized survey should be used throughout the LTC field. However, there are significant concerns about the CAHPS instruments. Key concerns include:

- The surveys are lengthy with more than 50 questions;
- The survey questions are dated and do not capture the crucial elements of person-centered care and choice which are paramount for residents. The survey has no questions that capture the experience of short stay resident. Currently short stay residents represent, on any given day approximately 14 % of those receiving care in LTPAC facilities; and
- The survey is designed to be administered by trained third-party interviewers. This presents challenges in the availability of an adequate pool of interviewers, interviewer bias, and the increased costs associated with conducting personal interviews; important factors for implement that must be addressed.

I. Regarding Payment, If Budget Neutrality Is Prescribed, CMS Should Consider An Approach That Does Not Punish Providers And Relies On Savings From The Reduction of Rehospitalization

In addition to the measurement challenge, CMS must also develop the payment methodology for a SNF VBP program. The demonstration methodology was required to be budget neutral. In meeting this restriction, CMS relied solely on savings that CMS believes were to be found in a decrease in avoidable rehospitalization comparing the demonstration and control groups. Given the demonstration projects were not designed to be statistically representative, it will be difficult to extrapolate findings to a national program.

While the statute mandating the SNF VBP plan is not specific, the Congressional Budget Office (CBO) scoring suggests that the national program will most likely also be required to be budget neutral. This approach suggests that incentive funding can only be achieved by taking from Peter to pay Paul. CMS has pointed out that one goal of the NHVBP demonstration is to demonstrate that Medicare savings can be achieved through a reduction in avoidable rehospitalization. It may be that, in the plan that CMS must provide to Congress, the agency will express consideration of a methodology that is budget neutral but does not take from one provider to reward another.

In addition, CMS will have to develop the award structure addressing issues such as quality performance versus quality improvement and the related award percentages.

XVII. Payment Adjustment for Hospital-Acquired Conditions

(Comments on Section IV.B: Payment Adjustment for Hospital-Acquired Conditions (Section 3008))

AHCA Recommendations on Payment Adjustment for Hospital-Acquired Conditions (HAC):

- *CMS should provide adequate and meaningful consultation with stakeholders from all post-acute settings and to integrate lessons learned from other quality and payment reform efforts;*
- *CMS should evaluate what conditions from the HAC apply to the SNF setting, since not all HACs apply to SNF setting;*
- *CMS should evaluate how data sources for indentifying HAC in SNF are different from the hospital setting;*
- *CMS should define how to attribute HAC to SNF when HAC was the result of care provided prior to admission to SNF;*
- *CMS should evaluate the unintended consequences of extending payment adjustments for HAC on access, cost and quality of care;*
- *CMS should prevent double jeopardy for HAC when a facility is cited and fined by Medicare Survey & Certification program for an HAC related F-tag and the facility also qualifies for payment adjustment due to their HAC rate;*
- *CMS should consider how managed care, private insurance and private pay patients will be included in the calculation of a provider's HAC rate;*
- *In expanding the HAC policy to SNFs, CMS should consider the plethora of programs indicated above in an effort to co-ordinate and perhaps integrate where possible and avoid redundancy and conflict;*
- *CMS should understand that the Medicare SNF PPS payment system does not lend itself to the financial negative adjustment envisioned by a HAC system; and*
- *CMS should crosswalk the Medicare SNF PPS with the hospital DRG system to ensure that an extension of the financial adjustment can be implemented correctly.*

A. Background

Section 3008(b) of the ACA directs the Secretary to conduct a study on expanding the already-existing preventable hospital acquired conditions (HAC) policy[39] to payments made in various post-acute settings, including SNFs. In developing this study, due to Congress no later than January 1, 2012, the Secretary is directed to include the impact of expanding the HAC policy on patient care, safety, and overall payments. The report must be accompanied by recommendations for legislation or administrative action as the Secretary deems appropriate.

[39] "HAC" refers to a hospital-acquired condition under Medicare. The Hospital-Acquired Conditions payment provision currently applies only to IPPS hospitals. For discharges occurring on or after October 1, 2008, Inpatient Prospective Payment System (IPPS) hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case is paid as though the secondary diagnosis is not present.

The HAC payment provision for inpatient DRG hospitals is one of CMS' value-based purchasing initiatives. The principle behind the HAC payment provision is that Medicare not pay for healthcare-associated conditions. In the ACA, Congress directed the Department of Health and Human Services (HHS) to establish a payment adjustment beginning in FY 2015 for hospitals that fall in the top quartile of national, risk adjusted HAC rates. For such hospitals, the payment amount for all discharges would be reduced by 1 percent.

B. Provision Of Adequate And Meaningful Consultation With Stakeholders From All Post-Acute Settings And To Integrate Lessons Learned From Other Quality And Payment Reform Efforts

CMS indicates in the SNF PPS Proposed rule that it is in the process of developing the report on the expansion of HAC policy to other providers. We ask that CMS, in preparing the report consult with all post-acute stakeholders since the CMS hospital method and approach to adjusting payments for HACs will not readily apply to other post-acute providers.

While we acknowledge and agree with CMS' desire to avoid spending Medicare dollars to correct preventable health care acquired conditions and create incentives for providers to avoid HACs, there are many critical clinical issues that must be addressed in any CMS attempt to apply existing HAC conditions or develop new health care -acquired conditions in the SNF setting.

It is also to be noted that at the current time, there is:

- A plan for SNF value-based purchasing on the CMS drawing board due to Congress on January 1, 2012;
- A recently issued final rule for Medicaid Payment for Provider Preventable Conditions pertaining to providers other than hospitals;
- ACO quality measures that participating and contracting SNF providers must support; and
- The development of a national, voluntary pilot program on payment bundling by January 1, 2013 required by Section 3023 calling for yet another set of quality measures. [40]

[40] Providers participating in the pilot are required to submit data to the Secretary on certain quality measures established by the Secretary. At a minimum, these quality measures must include:

- Measures of functional status improvement
- Reduction in avoidable hospital readmissions
- Rates of discharge to the community
- Rates of admission to an emergency room after hospitalization
- Incidence of health care acquired infections
- Efficiency
- Patient-centeredness of care
- Patient perceptions of care
- Other measures determined by the Secretary

- Quality Improvement Organization (QIO) program focus on reducing HACs.

In addition to the statutory and regulatory programs indicated above, strong nursing facility quality efforts have been underway for quite some time, most notably since 2002 with the onset of the Nursing Home Quality Initiative -- where provider collaborations were formed to address clinical issues, of which several fall under the HAC list (e.g. pressure ulcer prevention and management).

A multi-stakeholder-led executive group set the stage for the development of the current "Advancing Excellence in America's Nursing Homes" campaign, where providers across the country are now actively involved in improving clinical and operational outcomes. CMS, State Survey representatives, and the Quality Improvement Organizations are participants in this campaign. Many of our members have worked very hard to achieve quality excellence and have received the Baldridge National Quality Award Program recognition.

Overall, caution must be exercised in the process of layering yet another quality program such as the Medicare HAC program or some Provider Preventable Condition (PPC) variation upon the present construct and elements of the SNF efforts to date. Thus, the mandated study due to Congress by January 1, 2012 on the expansion of the HAC policy to other settings -- including the analysis of how such policies could impact quality of patient care, patient safety, and Medicare spending, -- is of critical importance.

AHCA believes that in expanding the HAC policy to SNFs, CMS should consider the plethora of programs indicated above in an effort to co-ordinate and perhaps integrate where possible and avoid redundancy, conflict and confusion. It should look to the success of past and continuing collaborative quality improvement efforts that have been forged by CMS, states, and providers. CMS' study should have the goal of helping SNFs and other post-acute providers to continue and enhance their quality improvement efforts. Lastly, in developing the study the agency should take into account the following clinical and payment issues pertinent to the post-acute SNF environment.

C. Evaluation Of HAC Conditions In The Hospital Setting That Might Apply To The SNF Setting

The list of conditions classified as HAC for the adjustment of hospital DRGs was developed for care and conditions unique to the hospital setting (e.g. wrong site surgery, retained foreign objects, etc.). An examination of the list of HACs in 42 CFR Parts 434, 438 and 447, indicates that many of the payment adjustments for provider preventable conditions including health care acquired conditions do not apply outside the hospital setting.

In addition, while others may apply outside the hospital setting, they are not readily transferrable to the SNF setting given the manner in which they are defined, indentified and recorded in the hospital setting. We recommend that CMS examine the current list of HACs and decide which

ones are "universal" across multiple different LTPAC settings and develop common definitions of these conditions.

D. Data Sources For Identifying HACs In SNFs Are Different From The Hospital Setting

Identifying HACs in the hospital system is predicated on using billing codes and additional codes added to the billing system. As described below, the SNF billing system does not readily allow for similar method to identify HACs. The MDS, an electronic standardized assessment form collected at admission and on regular intervals thereafter collects some information about HAC but not all information. For example, the look back period for information collected on the MDS varies at different assessment periods but does not cover all the time between assessments. The admission assessments have a look back period that can extend several days prior to admission thus capturing care or HAC that occurred prior to admission but would look like they occurred in the facility.

Unlike the hospital, nursing homes have to submit a large number of incidents to the state survey agency that works on behalf of CMS. Many of these "incidents' could be classified as HACs. Most of these "incidents" when evaluated by the SSA are not found to be of any significance or variation from standards of care. In addition, family members can also file complaints with the Social Security Administration (SSA). While using complaints or incident reports is a somewhat attractive method to identify HACs, not all HACs are required to be reported. Plus, the current system is designed to report suspected cases just as frequently as confirmed cases. The SSA often does not investigate these cases until the annual inspection period. Thus, the current system does not capture all cases and does not verify cases as attributable to the nursing home frequent enough to make this system reliable for inclusion in an HAC payment adjustment program.

E. Standardizing The Data Collection System And Definitions For HACs Across All Providers

Unlike the hospital setting where the billing system can be modified to capture information to identify HACs, the SNF and NF payment systems are not the same as used in the hospital setting and cannot be easily adapted to capture HAC conditions. The SNF system is based on a Resource Utilization Groups (RUGs) system, not diagnosis based system as used in the hospital.

In order to streamline the data collection system to identify HACs, we recommend that a single data collection and reporting tool, used across all settings impacted by the payment programs, be implemented to ensure standardization. Standardization is needed in the following areas:

- Definitions for Medicare, Medicaid, and dual-eligible patients;
- Condition definitions such as what is a fall and trauma; and
- Data collection timeframes such as the length of look-back periods or the number of times per specified period that care was received or the condition occurred.

CMS has already designed and is testing the CARE tool mandated by the Deficit Reduction Act with a report to Congress due by January 2012. It is a tool designed to be used across the various provider settings and to allow quality and cost comparisons. This tool is in the final stages of testing. AHCA recommends that if found sound, the tool be implemented before the Medicare HAC payment system is considered for other settings and before states develop HACs.

F. Defining How To Attribute HACs To SNFs To Avoid Misclassification When The HAC Was The Result Of Care Prior To Admission To The SNF

Patients in long term care facilities are admitted having experienced care and treatment from a wide variety of care providers -- primary care physicians, hospitals, and others. Uncoordinated and inconsistent care along the continuum can contribute to the development of HACs in the receiving setting.

Many of the HACs may be present on admission to the SNF since they developed in the hospital or other setting. This can be addressed similar to the Present on Admission (POA) process used in the hospital setting. However, the billing systems for SNF care (and Medicaid) differ from the hospital billing practices making a POA process not readily transferrable without modification. We recommend that CMS include in their plan an analysis of how POA would be incorporated into the SNF billing system.

In addition, many of the HACs may not manifest themselves until after admission but were the result of care prior to admission. For example, a DVT or Pulmonary Embolism may develop due to inadequate anticoagulation therapy in the hospital but not be diagnosed until after discharge to the SNF. Similarly, post surgical wound infections may not develop or become visible until after discharge from the hospital to the SNF but were the result of care practices in the hospital setting.

We recommend that CMS use an expert panel of physicians to identify the HACs that are most susceptible to this delayed identification and how one can attribute the provider responsible (and therefore assigned the HAC) for calculating their HAC rate. This attribution challenge also will apply to other LTC settings.

G. Evaluation Of The Unintended Consequences On Cost Quality And Access To Care Of Extending Payment Adjustment Methodology For HACs In The Hospital Setting To LTC Providers Such As SNFs

Unintended consequences can occur that result in harming the patient and increasing the cost of care. For example, the nursing facility which admits a high-risk patient with a Stage II, deep tissue injury (DTI), or unstageable pressure ulcer is at risk for being identified as causing a HAC if within a short period finds the ulcer to be at a Stage III or IV. There is no incentive for the

nursing facility to admit the high-risk patient, and if admitted and the HAC occurs, there is no incentive to keep the patient. Transferring the patient to another facility, who can identify the ulcer on admission and get reimbursed, is a reality.

Thus, we recommend that CMS not inadvertently create incentives to avoid caring for patients at higher risk of HACs and potentially further fragmenting care coordination, at a time when greater care coordination is needed most.

H. Prevention Of Double Jeopardy For HACs And Survey Citations

SNFs are subject to a federal compliance survey annually and in addition, inspections to investigate complaints. These surveys and inspections are conducted by trained independent State surveyors working on behalf of CMS. These inspectors evaluate closely if the nursing facility followed clinical standards of care. When a facility is found by the state survey agency to be non-compliant with federal regulations, depending on the severity of the noncompliance, the facility may be fined. The fines imposed can range from $100 to millions of dollars. Many of the citations and complaints relate to HACs.

Thus, we believe many SNFs already receive a financial penalty when HACs that has been evaluated and verified as attributable to the facility have occurred. Thus, we believe extending the hospital HAC payment reduction methodology to SNFs for HAC constitutes a double penalty. Also, since many of the HAC are evaluated by a CMS agent (e.g. state survey and certification inspector) to determine if standards of care were met, a global across the board payment reduction as done in the hospital settings is not necessary for the SNF setting.

I. Consideration Of How Managed Care, Private Insurance And Private Pay Patients Will Be Included In The Calculation Of A Provider's HAC Rate

When considering the implementation of a Medicaid or Medicare payment system in the long term care setting, thought needs to be given to how managed care, private insurance, and private pay patients will be handled in the identification and calculation of HAC rates for a facility. This is especially true if existing data collection sources are used to identify HAC. Many existing sources (e.g. MDS, reports to Survey & Certification Agency, State reporting programs) all collect information regardless of payor status and calculate rates for the facility for all patients or residents not just Medicare or Medicaid beneficiaries. Even though these patients are not part of the Medicare and Medicaid system, their presence in a nursing facility can impact MDS QM measurement used to determine a facility's HAC rate.

We recommend that all patients regardless of payor status be included in calculating the HAC rate for a provider. This would reflect the practices of the facility as a whole and would provider larger denominator size and more stable number. However, if such an approach is used, we strongly recommend that this approach apply to other providers as well otherwise nursing facilities would be disadvantaged compared to other LTC providers and hospitals. In addition,

the need for risk adjustment will also be necessary since the inclusion of these patients can alter facility acuity scores. Facilities that specialize or have larger than average populations of non Medicare or Medicaid patients could look different than facilities with more Medicare and Medicaid patients. Thus, a system that mimics the hospital system and ranks nursing homes' based on their overall HAC rate could classify some homes in the top quartile inappropriately without adequate risk adjustment.

J. CMS Should Cross Walk The Medicare SNF PPS Payment System With The Hospital DRG System, To Ensure That An Extension Of A Financial Adjustment Can Be Implemented Correctly

The Medicare SNF PPS payment system does not readily lend itself to the financial adjustment employed by the Hospital DRG system. The HAC hospital payment system calls for isolation for nonpayment of the portion of the payment directly related to treatment for, and related to, the provider-preventable condition. This type of payment isolation is predicated on a payment coding system used in the inpatient hospital prospective payment system (IPPS).

In the IPPS, when a HAC is identified, the care of that HAC is identified by code, and Medicare does not allow the hospital to be paid for that HAC.[41] The SNF PPS payment system is not predicated on this approach. The SNF PPS payment system utilizes an acuity adjusted "case mix" per diem system that reimburses SNFs based on a completed MDS assessment based on patient's clinical status and intensity of services provided.

When a patient suffers a HAC, in many cases it would not result in an increased payment in the SNF setting due to the presence of other significant comorbid conditions and a payment system not based on diagnoses. For example, it is difficult to disaggregate the portion of the cost of care attributed solely to the treatment of a UTI or DVT and what additional care may be associated with the individual's co morbid conditions and overall decline in status. Over 80% of the SNF payment is based on the intensity of rehabilitation services. Thus, the RUG assigned to a resident that determines reimbursement may not be altered by the presence of many of the hospital HACs, unlike in the hospital DRG system.

The law and regulations were clearly designed for the hospital setting where an average length of stay can be measured for a particular condition, and if a patient exceeds that length of stay and incurs more costs due the development of a HAC, those costs to Medicare are also relatively easy to measure.

In addition, most aged residents in NFs remain in the facility for prolonged stays, some indefinitely until they die. Consequently, it will be very difficult to determine when the effect of

[41] "HAC" refers to a hospital-acquired condition under Medicare. The Hospital-Acquired Conditions payment provision applies only to IPPS hospitals. For discharges occurring on or after October 1, 2008, Inpatient Prospective Payment System (IPPS) hospitals do not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization (i.e., was not present on admission). The case is paid as though the secondary diagnosis is not present.

a HAC ceases (ending the payment reduction related to a particular condition), and when the continuing need for additional care may be related to a separate comorbid condition and the resident's overall decline.

Moreover, even if a HAC can be attributed to the SNF, in the most severe cases the development of an HAC will result in an increase in the cost of care (e.g., a fall with a hip fracture that requires surgery), but the resident will not necessarily be receiving any additional care at the SNF. Rather, the resident will be transferred to a hospital for surgery and post-surgical care.

In conclusion, we believe extending the HAC payment adjustment methodology used for the hospital setting to LTC and SNF setting is not possible and may further fragment care coordination at a time when the need for greater care coordination is being acknowledge. We recommend CMS explore other options and incentives to address HACs in the LTC setting rather than assuming the method used in the hospital setting works for nursing facilities.

XVIII. Disclosure Of Ownership And Other Information

(Comments on Section V.A: Required Disclosure of Ownership and Additional Disclosable Parties Information (Section 6101))

AHCA Recommendations on Required Disclosure of Ownership and Additional Disclosable Parties Information (Section 6101):

- *CMS should minimize the burden of the additional disclosure of ownership and additional parties information required under the ACA*

A. Background

In the Proposed rule, CMS proposes to implement Section 6101 of the ACA, which requires Medicare SNFs and Medicaid nursing facilities ("NFs") to disclose expanded information on the facility's ownership, organizational structure and "additional disclosable parties" as a condition of continued enrollment in the Medicare and/or Medicaid programs. Specifically, Section 6101 amends Section 1124 of the Social Security Act to require facilities to make available for submission to the Secretary, the Inspector General of HHS, the state in which the facility is located and the state long-term care ombudsman certain additional information beyond the ownership information required to be submitted in Sections 1124(a) and (b) of the Social Security Act by other Medicare providers. The statute, as amended, adds a new paragraph (c) to require SNFs and NFs to submit information on: (1) each member of the governing body of the facility (including name, title and period of service); (2) each officer, director, member, partner, trustee, or managing employee of the facility (including name, title, and period of service); and (3) each "additional disclosable party" (as defined) of the facility. Information on the organizational structure and a description of the relationship of each additional disclosable party to the facility and to one another must also be disclosed. The law also provides that if a nursing facility already reports any of this information to the Internal Revenue Service (on Form 990), the Securities and Exchange Commission, or information "otherwise submitted to the Secretary or any other Federal agency," the nursing facility can submit any of those forms or documents to satisfy the disclosure requirement. Section 1124(c)(2)(B) of the Social Security Act.

Under Section 6101, by March 2012, HHS is required to issue regulations that create a standardized format for reporting the information specified in Section 6101. Specifically, the statute, amended (Section 1124(a)(3(A)) provides:

> Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in

accordance with such final regulations is, to the best of the facility's knowledge, accurate and current.

The law also specifies that HHS will provide guidance and technical assistance to states on how to adopt the standardized format for receiving this information.

By March 2013, HHS must make the ownership and additional disclosable party information submitted on the standardized form available to the public. Beyond the requirement for facilities to submit information within 90 days of the final regulations and for HHS to make information available to the public, there is no other effective date provided in Section 6101. Therefore, AHCA has interpreted 6101 to be effective upon enactment of the ACA.

In sum, the law significantly expands the information SNFs and NFs must disclose about their ownership, operations, and their relationships with third parties, specifically "additional disclosable parties."

By email dated May 17, 2010, AHCA provided preliminary comments to CMS on several aspects of the ACA, including Section 6101. In this communication, AHCA sought clarification on several aspects of how CMS intended to implement Section 6101, including definitions and the time periods for reporting changes. AHCA also strongly suggested that CMS convene affected stakeholders, including corporations of individually-owned nursing homes and multi-facility companies, to assist in the development of the standardized form for disclosure purposes. While AHCA is pleased to note that in the Proposed rule CMS apparently considered some of AHCA's initial comments, regrettably there has not been any direct involvement of nursing facilities in developing what undoubtedly will be an extremely resource-intensive and complex process. Therefore, AHCA renews its recommendation that CMS convene stakeholders in the development of the standardized form, alternatives for disclosure and the key definitions and mechanics for completion.

In these comments, AHCA first responds to CMS' assertion that these proposed expansive, burdensome and in many cases impractical requirements for information disclosure are needed because owners of long term care facilities have lacked transparency in ownership disclosure, or because privately-owned facilities have adopted "schemes" to shield themselves from liability or reduce necessary resident care and services. Second, AHCA responds to the Proposed rule itself as to how and when facilities will submit ownership and other organizational information – and the scope of this information -- consistent with Section 6101.

B. Long Term Care Facilities Owners By Private Investment Provide High Quality Care Compatible By Other Organizations

In the preamble to the Proposed rule, CMS claims that the additional ownership and operational information mandated by Section 6101 is required to provide transparency regarding who is responsible for resident care. The agency cites to a 2007 *New York Times* article alleging that facilities owned by private investment firms cut costs by decreasing staff and services.[42] CMS also asserts that its own data showed that in 60 percent of the acquisitions of facilities by large

[42] *76 Federal Register, 26385.*

private investment group, the number of clinical registered nurses were cut "far below levels required by the Medicare long-term care facility participation requirement under 42 C.F.R. § 483.30," implying erroneously that there are federal nurse staffing requirements.[43] The preamble also references a 2010 Government Accountability Office ("GAO") report to Congress in which CMS claims the GAO made "similar findings,"[44] and that Senate hearings held in 2007 found that "legal schemes" were being used by investment firms to shield themselves from liability. While conceding that certain ownership information was available to the public upon request, CMS claimed that the complexity of private investment ownership made it difficult for residents and families to understand who is responsible for resident care at the facility.[45]

AHCA is deeply disappointed that CMS continues to propagate the misinformation on private investment in long-term care facilities discussed in the September 2007 *New York Times* article and subsequent hearings. In fact, more recent studies have largely discredited the conclusions in this article. For example, the highly-respected researchers at PointRight (formerly known as at LTCQ, Inc.) analyzed the article and private-equity ("PE") owned facilities, and found that the article was "based on the application of problematic analytic techniques to problematic data." They noted the statistical and analytic flaws in the article, and the erroneous assumptions that somehow corporate ownership structures lead to poor quality care. They concluded:

> An unequivocal conclusion of LTCQ's study of over 800 PE-owned facilities is that ownership by a PE firm and operation by a different organization is compatible with the highest quality of care. Problems with care quality that do exist at some facilities owned by PE groups relate to the operations of the specific facility and not to ownership arrangements as such."[46]

Similarly, Florida's state agency responsible for licensure and certification of long term care facilities, the Agency for Health Care Administration ("the Agency") conducted an extensive study of ownership of facilities and quality of care. The Agency concluded, "There is no evidence to support that the quality of nursing home care suffers when a facility is owned by a private equity firm or an investment company."[47]

In fact, it is noteworthy that in the nearly four years since the *New York Times* article and related congressional hearings, CMS cites to no more recent data showing any credible connection between ownership structures and quality of care. That is because no such data exists. The GAO report cited by CMS in the preamble does not conclude that there is any connection between private investment and quality of care or efforts to "shield" owners from responsibility for the operation of facilities. Rather, the GAO report identified the shortcomings in CMS' Provider Enrollment, Chain, and Ownership System ("PECOS"), the national database of

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[43] *Id.*

[44] Nursing Homes, Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data, September 2010, GAO-10-710

[45] *Id.*

[46] See LTCQ, Inc., Acquisition of Nursing Home Chains by Private Investment Groups Abbreviated Analysis of the New York Times Article (November 6, 2007).

[47] "Long Term Care Review: Florida Nursing Homes Regulation, Quality, Ownership, and Reimbursement," prepared by the Florida Agency for Health Care Administration (October 2007), p. 24, available at http://www.fdhc.state.fl.us/LTCwhitepaper.shtml.

enrollment information submitted to CMS by Medicare providers through Form CMS-855. Specifically, the GAO found that PECOS provided a confusing picture of the complex ownership structures and chain affiliations of the six private investment-owned nursing home chains GAO reviewed. The database did not provide any indication of the hierarchy or relationships among the numerous organizational owners listed for these nursing homes. Further, private investment ownership was often not readily apparent in the data. The GAO surmised that this lack of clarity could be the result of:

- PE firms not being required to be reported because of how they structured their acquisitions,
- Provider confusion about the reporting requirements, or
- Related entities that were reported but were not easily identifiable with the PE firms.

AHCA agrees with these observations but emphasizes, as we have in prior communications to CMS and meetings with CMS officials, that there are inherent problems in the PECOS system which limit the accuracy and completeness of the information that is submitted and maintained by CMS. Most importantly, as discussed below, if PECOS and the Form CMS-855A are to be the "standardized format" for submissions of the expanded information required by Section 6101, CMS will need to make substantial improvements to the PECOS system. CMS has acknowledged the need for those changes, and AHCA has helped to support those efforts, but the Proposed rule lacks any detail on how those changes would be achieved.

In sum, AHCA fully supports the goal of providing information to residents and their facilities in order for them to make informed decisions about nursing facility care, and furnishing relevant information about facility ownership and organizational structure to CMS. We continue to strongly dispute the contention that current Medicare and Medicaid ownership disclosure requirements in any way enabled owners to avoid responsibility for resident care or that burdensome and complex ownership disclosure is required to address a problem that does not exist.

C. Comments On Proposed Rule Standardized Format

In the proposed rule, there is no mention of a standardized format for disclosure of required information. As noted, Section 6101 expressly requires HHS to issue regulations in the *Federal Register* to develop a "standardized format" for disclosure of information required by law. CMS does indicate in the preamble that it will use the PECOS for Medicare SNFs, "which will be revised to capture the additional information requirements" under the Proposed rule.[48] CMS also states that "Form CMS-855A will be revised so that it collects the additional information required by this proposed rule from Medicare providers." However, no where in the proposed rule does CMS expressly state that PECOS or the Form CMS-855A is the standardized format required under Section 6101. Moreover, contrary to the statute, CMS does not indicate how it intends to provide guidance to states on use of the standardized format for Medicaid NFs, or whether this will be left to the state Medicaid programs. CMS states that it will seek OMB approval for revisions to the Form CMS-855A to collect the information required from Medicare

[48] *76 Federal Register, 26398.*

providers in a separate notice and comment period.[49] Again, however, there is no indication whether this is the "standardized format" required by Section 6101. Therefore, AHCA requests that CMS clarify whether the 855A is the standardized format for disclosure purposes and whether this form (or some version of it) will be used by Medicaid programs for NFs.

Moreover, notably absent from the Proposed rule is any indication how CMS will comply with the ACA's requirement that facilities that have submitted ownership or organizational structure information to HHS or other Federal agencies (including the Internal Revenue Service on Form 990 or the Securities and Exchange Commission) be permitted to submit such documents to satisfy the requirements of Section 6101. AHCA believes that avoiding duplicative submissions is critical to minimizing the burdensome nature of the Proposed rule on facilities, consistent with Congressional intent. AHCA requests clarification of this provision in the final rule.

D. Definition Of "Additional Disclosable Party"

In the Proposed rule, CMS essentially adopts the definition of "additional disclosable party" from the statute. Section 1124(c)(5)(A) of the Social Security Act. We are pleased to see that CMS acknowledges that given this exceedingly-broad definition, it would be difficult for SNFs and NFs to reasonably know which parties and individuals associated with their facility meet this definition. CMS therefore expressly solicits comments on how best to narrow the scope of the definition to apply to parties and individuals that are capable of exercising actual operational, financial or managerial control over the facility or performing the other functions indentified in Section 6101.[50]

In some circumstances, it will be impracticable for facilities to reasonably know ownership information beyond the entities with which they have direct contact (e.g., a lender, a landlord). Also, where a facility engages consultants to provide policies and procedures, AHCA submits that those individuals do not exercise any actual control, since such policies and procedures must ultimately be adopted by the facility itself.

Therefore, AHCA recommends that CMS provide clear, bright-line definitions that will be easy for facilities to understand and that go to the core functions of owning and operating a facility. In fact, some of the entities and persons described in (c)(5)(A) are already addressed in Sections 1124(a) and (b). Specifically, AHCA recommends simplifying the definition as follows:

Additional disclosable party means any person or entity who:

- Exercises operational, financial, or managerial control over the ***day-to-day operations of the facility***, or provides policies or procedures for any of the operations of the facility (to the extent not separately adopted by the facility), or provides day-to-day financial or cash management services to the facility.

- Leases or subleases real property to the facility pursuant to a written lease agreement; or

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[49] *76 Federal Register, 26399.*

[50] *76 Federal Register, 26398.*

- Provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility **involving the day-to-day operations of the facility.**

We also suggest CMS provide guidance to facilities to help them make this analysis:

- ☐ Does the facility use another party as a management company?
- ☐ Does another party create policies/procedures for any of the facility's operations?
- ☐ Does another party provide financial, cash management, or accounting services to the facility?
- ☐ Does the facility lease its property from another party?
- ☐ Does another party own any part of the facility's property?
- ☐ Does the facility use another party for administrative services?
- ☐ Does the facility use another party for clinical consulting services for the day-today operations of the facility?

E. Definition Of "Managing Employee"

In the Proposed rule, CMS proposes to define a "managing employee" of a facility very broadly to include individuals who are under contract or, through some other arrangement, exercise operational or managerial control over or, directly or indirectly, conduct the day-to-day operation of the facility. This includes consultants or anyone who "advises or supervises any element of the practices, finances or operations of the facility" and anyone who supervises any aspect of the facility's operations. This could include, for example, a charge nurse supervising one wing of the facility or a housekeeping manager overseeing the facility's housekeeping staff.

AHCA submits that this definition is overly broad and that it would be extremely difficult for SNFs and NFs to reasonably know which parties and individuals associated with their facility meet this definition. What is meant by "any element of" the practices, finances or operations of the facility? What is meant by "directly or indirectly?" Also, this definition seems to overlap with the definition of "additional disclosable party."

Again, AHCA strongly urges CMS to provide a simple and straightforward definition of managing employee. This will typically be the Administrator or Executive Director of the facility. Since these individuals are ultimately responsible for the operation of the facility, any consultants or advisors who provide service to the facility are simply assisting the Administrator fulfill his or her duties as the individual responsible for day-to-day operations of the facility. Also, if the intent is to identify the corporate or home office legal entity that provides operational control or management services to the facility, AHCA suggests that the regulation expressly state "parent company or home office company" rather than vague and overly broad terms for which there can be multiple interpretations.

F. Definition And Disclosure Of "Organizational Structure"

In the proposed rule, CMS essentially adopts the definition of "organizational structure" from the statute. Responding to CMS' request for comments to narrow these terms in a way that makes the rule workable, consistent with Congressional intent to understand the organizational structure of the facility, we respond as follows:

- For limited partnerships (proposed 424.502 and 455.101), as a matter of law, only the General Partner is capable of taking actions or impacting the operations of the business entity. The limited partners have no ability to make decisions or effect the operations of the entity, regardless of their ownership interest. Also, many limited partnership arrangements have confidentiality agreements under which the identities of the limited partners cannot be disclosed. Therefore, we recommend that subparagraph (4) be revised to require for a limited partnership, disclosure of the general partner(s).

- In the proposed rule, CMS states that each SNF or NF also must report the organizational structure of each "additional disclosable party" and the relationship of each additional disclosable party to the facility and to each other. This proposal is simply unknowable and impracticable. A facility has no means to find out the organizational structure of entities with which they do business, as that is typically proprietary and confidential information. Moreover, there is no realistic way for a facility to know what relationships the additional disclosable party may have with other disclosable parties. By way of illustration, assume that a facility leases property from a bank that has a real estate holding company. The bank is an additional disclosable party, and the facility would disclose that entity. The bank may have arrangements with other facilities, with other individuals, etc. The Administrator could have a checking account at the bank. The company's accountant could provide accounting services to a division of the bank. In other words, the myriad connections between and among the additional disclosable parties is simply unknowable. More importantly, even if a facility could get this information, it does not have any bearing on the ownership and operation of the facility. AHCA believes it is reasonable for a facility to disclose its own organizational structure, but further obligations to report organizational structures of additional disclosable parties – over which the facility has no control and from whom it has no right to obtain this information – cannot be implemented and should not be required.

G. Time Periods For Reporting Changes And Updates To Reported Information

In the Proposed rule (424.516(4)), CMS proposes that the information required would be reported upon enrollment and within 30 days of any change. In the preamble, however, CMS seeks comments on a potential alternative approach in which CMS would collect this information only upon revalidation consistent with the requirements in 424.515.[51] AHCA completely agrees with CMS that 30 days is far too short of a period to report changes in the

[51] *76 Federal Register, 26398.*

extensive amount of information that will be required to be reported. Indeed, in large organizations, it would likely be necessary to have one person whose sole job was to report changes. Therefore, we strongly support CMS' proposal to require only updating upon revalidation (including any off-cycle revalidations) as a means to limit the burden on Medicare SNFs. We encourage CMS to advocate this position with state Medicaid programs as well.

Appendix A: Acuity Changes

SNF Resident Acuity
October 1, 2008 - April 30, 2011

Prepared for AHCA

June 17, 2011

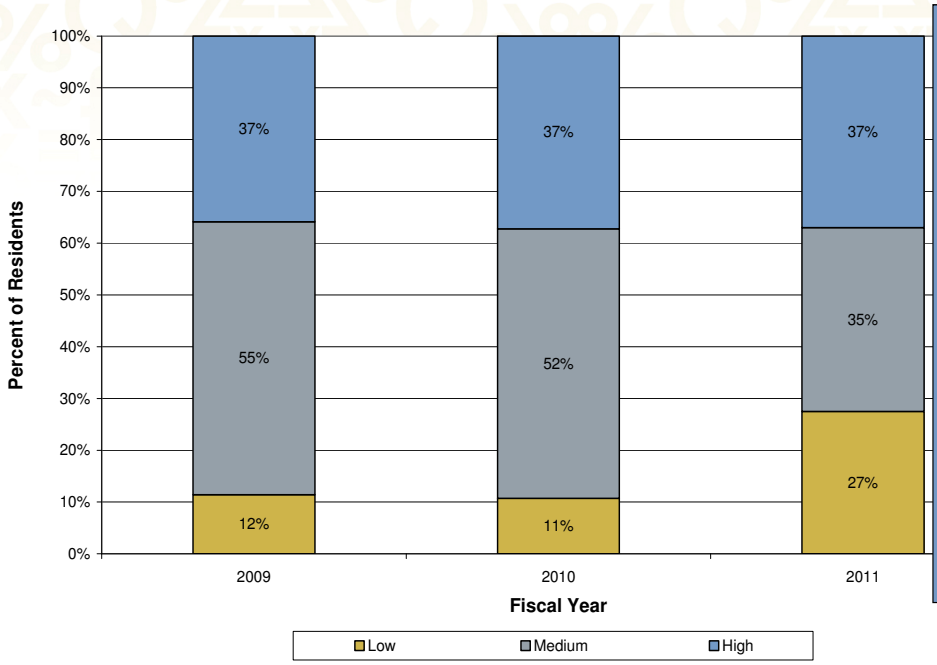
Highlights

- Overall resident acuity did not decrease from FY-2009 and FY-2010 to Q2 FY-2011
- The changes in the calculation of the ADL score from MDS 2.0 to MDS 3.0 may account for a *decrease* in the percent of residents with moderate ADL impairment
- The percent of residents with severe cognitive impairment, depression and pain *increased* with the implementation of new assessment scales in MDS 3.0
- The average number of diagnoses *increased* while average number of infections did not change

Background

- PointRight analyzed MDS assessments from October 1, 2008 through April 30, 2011, to measure these proxies for acuity:
  - Activities of Daily Living
  - Cognition
  - Depression
  - Diagnoses and Infections
  - Pain
  - Fall Risk
  - Personal Severity Index
  - Pressure Ulcer Risk
- The purpose of the study was to analyze changes in the measurement of acuity from MDS 2.0 to MDS 3.0

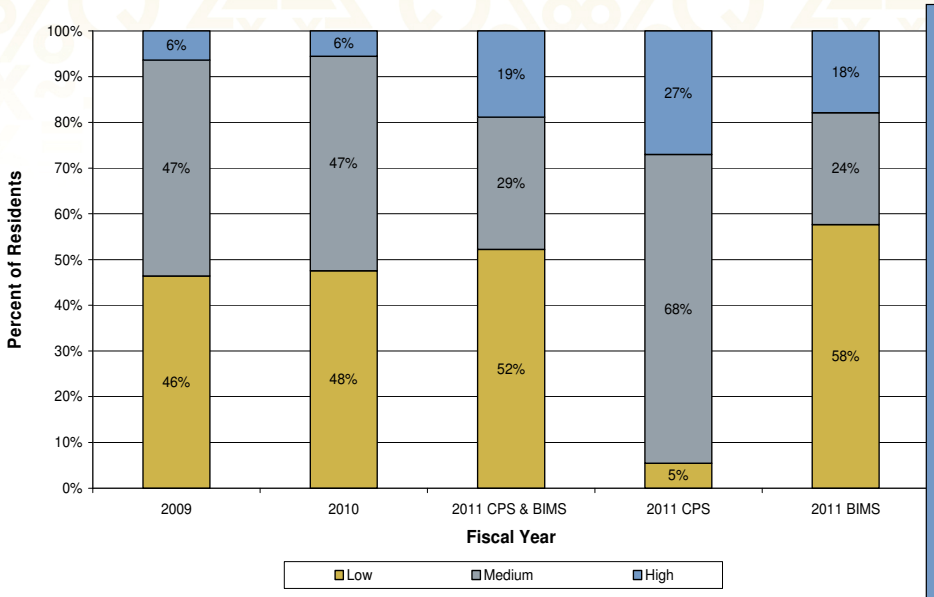
Resident ADL Scores by Year



The percent of residents with high ADL scores has not changed from October 1, 2008 through April 30, 2011. The percent of residents with low ADL scores has increased under MDS 3.0.

Changes in the ADL scoring calculation in RUG-IV may account for this change.

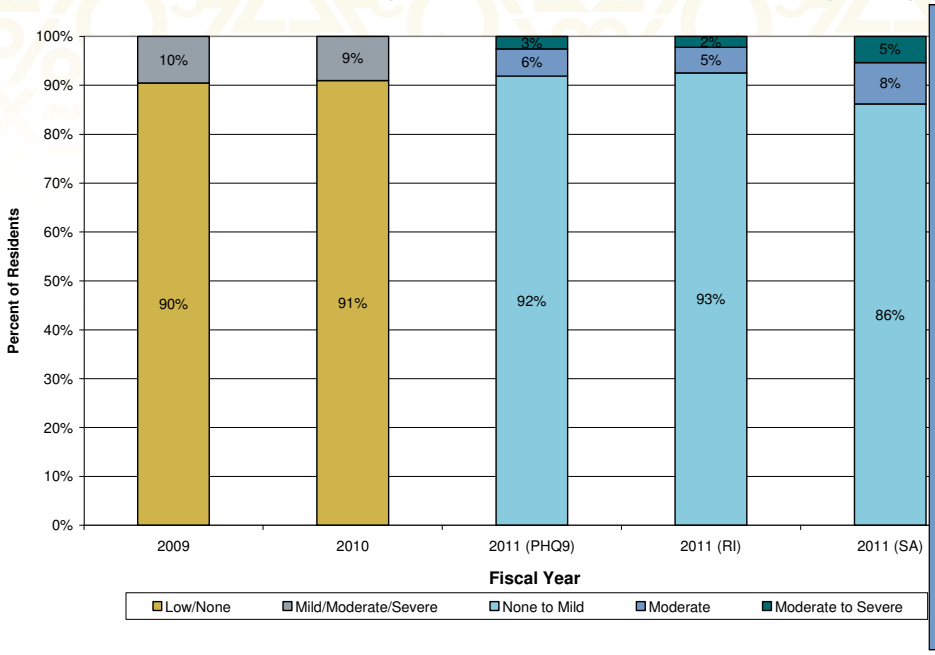
Resident CPS and BIMS Scores by Year



The percent of residents with highly impaired cognition has increased from October 1, 2008 through April 30, 2011.

The change to the BIMS resident interview in MDS 3.0 may account for some of this increase. The difference in the CPS from MDS 2.0 to 3.0 may be related to the smaller denominator size.

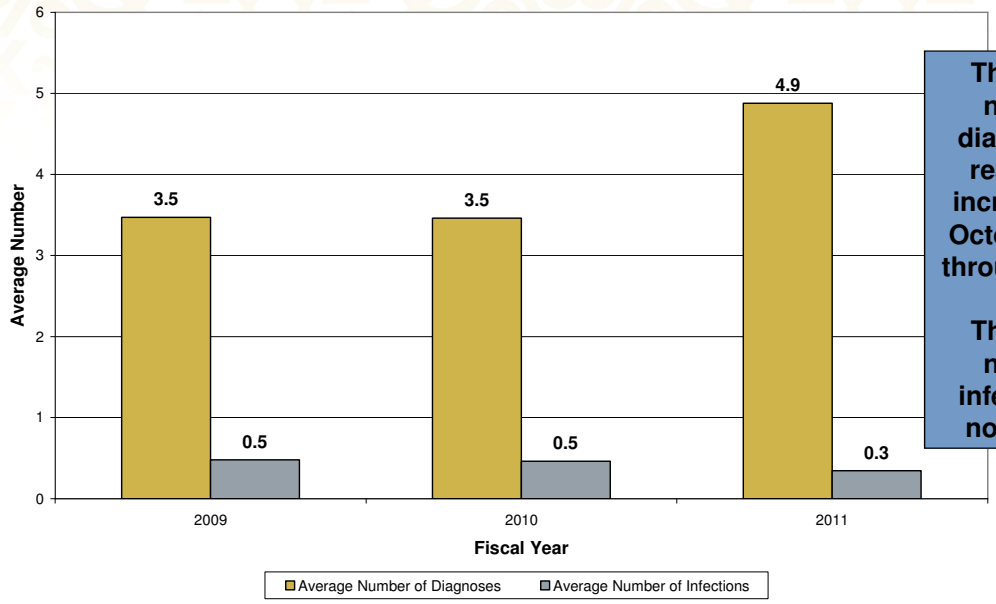
Resident Depression Severity by Year



The overall percent of residents with moderate to severe symptoms of depression has not changed from October 1, 2008 through April 30, 2011.

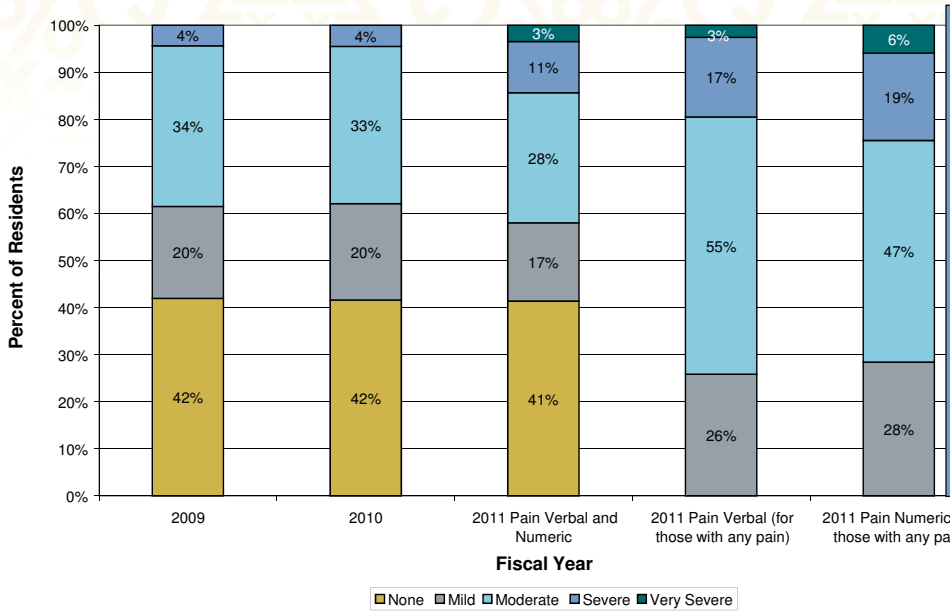
However, the staff assessment (PHQ-9-OV) has identified slightly more residents with moderate to severe symptoms of depression than the MDS 2.0 staff assessment.

Average Number of Diagnoses and Infections Per Resident



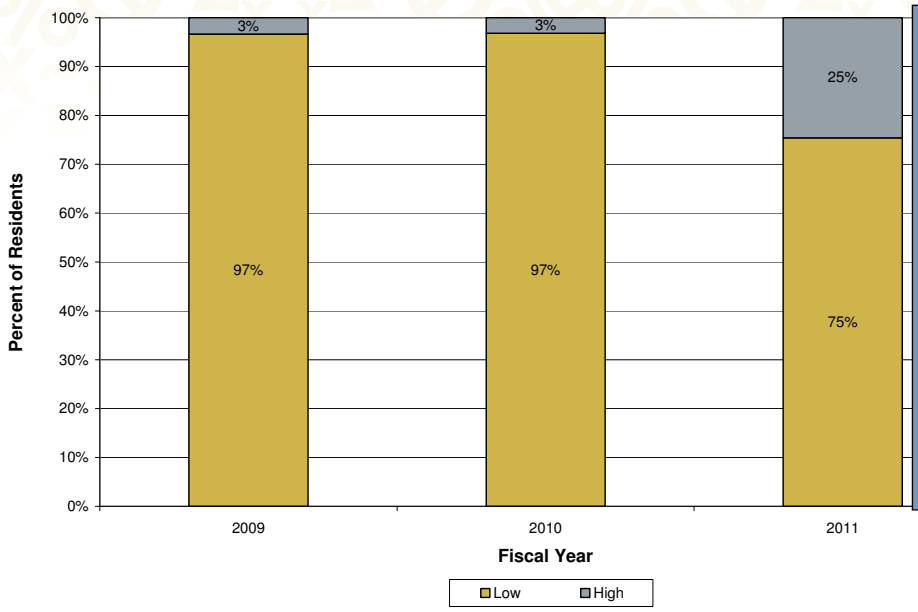
The average number of diagnoses per resident has increased from October 1, 2008 through April 30, 2011.
The average number of infections has not changed.

Resident Pain Severity by Year



The overall percent of residents with any pain did not change from MDS 2.0 to MDS 3.0.
However, the proportion of residents with pain that was moderate or severe significantly increased.

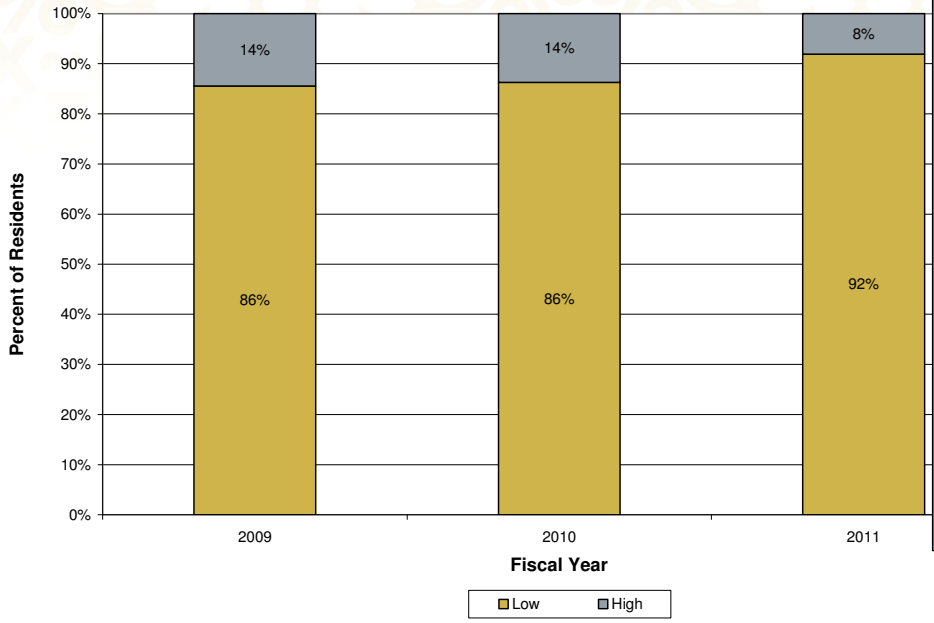
Resident Risk for Falls by Year



The percent of residents at high risk for falls has increased from October 1, 2008 through April 30, 2011.

Note that the PointRight predictive modeling of resident risk has changed from MDS 2.0 to MDS 3.0.

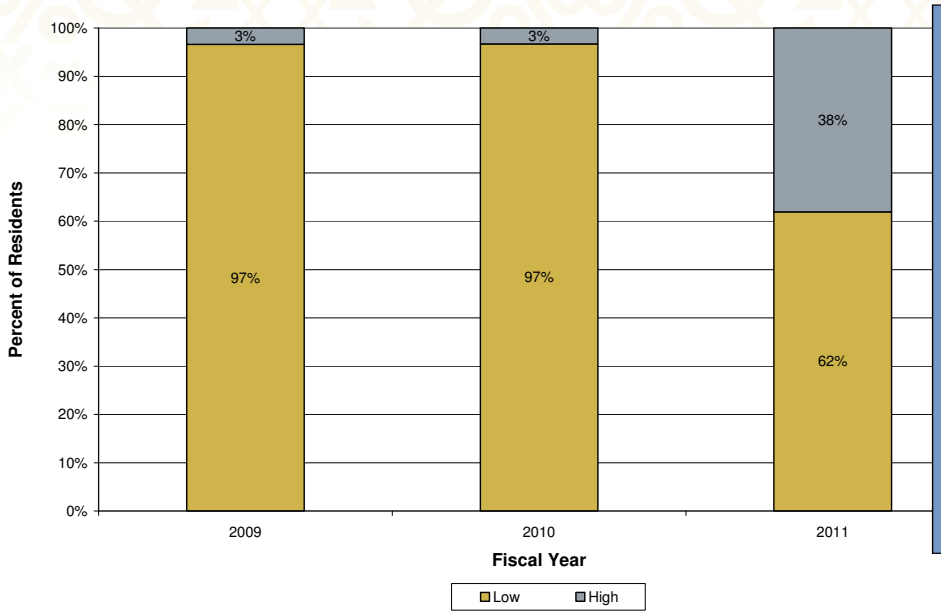
Resident Personal Severity Index (Frailty) by Year



The percent of residents who scored high on the Personal Severity Index has decreased from October 1, 2008 through April 30, 2011.

Note that the PointRight predictive modeling of resident risk has changed from MDS 2.0 to MDS 3.0.

Resident Pressure Ulcer Risk by Year



The percent of residents at high risk for pressure ulcers has increased from October 1, 2008 through April 30, 2011.

Note that the PointRight predictive modeling of resident risk has changed from MDS 2.0 to MDS 3.0.

Comments

- ADL Score: The self performance code of '8' (total dependence) does not add to the score in RUG-IV
  - In RUG-III '8' would add 4 or 5 to the total score depending on staff support
- Also, IVs and feeding tubes do not add to the ADL score in RUG-IV
  - In RUG-III this would be an automatic score of '3' for eating
- Cognition: In MDS 2.0 all residents were assessed by staff using the Cognitive Performance Scale (CPS)
  - In MDS 3.0 the number of residents assessed using the CPS is lower due to the resident interview option (BIMS)
    - The denominator size is smaller in MDS 3.0 CPS

Comments (cont.)

- Number of diagnoses/infections: ICD-9 codes were not used in this study due to the potential for duplication of the checklist items
  - The total number of diagnoses in the checklists are comparable from MDS 2.0 (55 items) to MDS 3.0 (56 items)
    - Note that Respiratory Infection is not an item on MDS 3.0
- Pain Severity: Only the resident interview for pain was included in this study in order to compare the self-report of pain severity on MDS 3.0 to the staff assessment of pain severity on MDS 2.0

Final Note

- For questions or additional information please contact:
  - Cheryl Caswell, Director of Research
  - cheryl.caswell@pointright.com
  - 781-457-5934

    or
  - Jennifer Gross, Senior HealthCare Specialist
  - jennifer.gross@pointright.com
  - 781-457-5916

Appendix B: State Medicaid MDS 3.0 Letters

REC'D 4/9/11

North Carolina Department of Health and Human Services
Division of Medical Assistance

1985 Umstead Drive – 2501 Mail Service Center - Raleigh, N.C. 27699-2501

Beverly Eaves Purdue, Governor
Lanier M. Cansler, Secretary

Craigan L. Gray, MD, MBA, JD, Director

April 6, 2011

[redacted]

Re: Third Quarter Reimbursement Rates ~ Effective April 1, 2011 to June 30, 2011
Provider Numbers: [redacted]

This letter is to inform you of the 3rd Quarter Medicaid Reimbursement Rate for the fiscal year ending September 30, 2011. The effective 3rd quarter date for this rate change is April 1, 2011.

Final Case Mix Report as of September 30, 2010 - Average CMI for Medicaid Residents = 1.3310

Facility Specific Direct Care Rate	$126.03
Indirect Rate	$31.85
Fair Rental Value Add-On	$ 5.96
Facility Fee Assessment	$12.75
Medicaid Reimbursement Rate and Nursing Facility Fee Assessment	**$176.59**

Due to uncertainties with MDS 3.0, DMA is reusing the CMI for period ending September 30, 2010. For more information related to the case mix rosters and update process, please contact Myers & Stauffer at (800) 763-2278.

The Division of Medical Assistance Provider Monthly Fee Assessment Form and instructions are located at http://www.dhhs.state.nc.us/dma/cost/nfassessment.htm. Note that the fee assessment forms and payments are due on or before the 15th of every month.

Should you have any questions regarding your rates, please contact the Nursing Home Rate Analyst at 919-855-4203.

Sincerely,

Brian K. Passineau
Rate Analyst
Finance Management

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

David A. Cook, Commissioner

Nathan Deal, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia.gov

MEMORANDUM

Date: May 17, 2011

To: Nursing Facility Administrator

From: Darryl Threat, Program Manager DT
Nursing Home Reimbursement

Subject: Rate Effective April 1, 2011

The Department has concluded that the case mix data obtained from the MDS assessments from the quarter ending December 31, 2010 is not reliable for calculating Medicaid reimbursement rates effective April 1, 2011. Therefore, your nursing facility will continue to receive its rate effective January 1, 2011 through June 30, 2011.

Enclosed are the results of your facility's Fair Rental Value (FRV) property per diem review. If your facility's FRV rate changed as a result of this review, you will have a revised billing rate effective January 1, 2011. Please follow the procedures outlined in Appendix I of the Policies and Procedures for Nursing Facility Services manual if you wish to appeal your revised rate. Retroactive adjustments covering the periods July 1, 2009 through December 31, 2010 will be made by the Department for those facilities that do not appeal the revised rate. If your facility appeals the revised rate, retroactive adjustments will not be made until the appeal process is completed.

If you have any questions, please contact me at (404)651-7886 or Angelica Foye at (404) 463-2956.

DCT

Enclosure

Appendix C: History of Medicare PPS Phase-Ins

Appendix C: Brief History of Phase-In of Changes to other Medicare Payment Systems

June 27, 2011

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Inpatient Hospital PPS	Implementing the new cost-based weight methodology in a 3-year transition, starting with FY 2007 as year 1	Three years for implementation of cost-based weights (FYs 2007-2009)	Year 1: 33% cost-based weight, 67% charge-based weight; Year 2: 67% cost-based weight, 33% charge-based weight; Year 3: 100% cost-based weight	Budget neutral; range of impact in first year was +0.7% to -2.2%	71 Fed. Reg. 47,870 (Aug. 18, 2006) – IPPS Final Rule 73 Fed. Reg. 48,434 (Aug. 19, 2008) – IPPS Final Rule 75 Fed. Reg. 50,042 (Aug. 16, 2010) – IPPS Final Rule 76 Fed. Reg. 25,788 (May 5, 2011) – IPPS Proposed Rule
	**********	**********	**********	**********	The TMA, Abstinence Education, and QI Programs Extension Act of 2007 mandated a payment reduction of 0.6% in FY 2008 and 0.9% in FY 2009, in lieu of the three-year prospective payment reduction finalized by CMS in the FY 2008 IPPS Final Rule. CMS originally planned a 1.2% reduction in FY 2008, a 1.8% reduction in FY 2009, and a 1.8% reduction in FY 2010 to maintain budget neutrality/ eliminate the estimated effects of nominal changes in coding
	Conversion from DRGs to MS-DRGs over 2 years, starting in FY 2008	Two years for conversion to MS-DRGs (FYs 2008-2009) Two years for retrospective, non-cumulative payment adjustment (FYs 2011-2012)	0.6% reduction in FY 2008; 0.9% reduction in FY 2009 2.9% reduction in FY 2011 (recoupment); 2.9% reduction in FY 2012, off-set by a 2.9% restoration; 2.9% restoration expected in FY 2013	Industry projected that 4.8% reduction to hospital payments spread over three years (as originally proposed for FY 2007) would have equated to a $20-24 billion reduction over five years The difference between the 0.6% reduction and the	

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
		Two years for a prospective payment adjustment (FY 2012 and an additional unspecified year).	3.15% proposed reduction for FY 2012 as a prospective adjustment. CMS estimates an additional 0.75% prospective adjustment is still needed in future years to return the payment system to budget neutrality	1.2% reduction in FY 2008 was approximately $665 million The 1.9 percentage point increase in FY 2008 resulted in an increase in aggregate payments of approximately $2.2 billion; the total 3.9 percentage point increase in FY 2009 will result in an aggregate payment of approximately $4 billion An aggregate 6.8% increase resulted in an increase in aggregate payments of approximately $6.9 billion	under the new MS-DRG system. The legislation also mandated further (unspecified) reductions in FYs 2010, 2011 and 2012, if necessary to return the payment system to budget neutrality. Congress mandated the smaller adjustments for FYs 2008 and 2009, superseding the CMS adjustments for those years. The legislation was enacted after the final rule was issued but before the reductions in the rule were implemented.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Home Health Agencies	New home health PPS implemented in CY 2001. In CY 2008, CMS found an estimated 11.75% increase in case-mix between CYs 2000 and 2003 that was attributable to nominal changes in case-mix. In CY 2011, further analysis of new case-mix data found that there was a 17.45% increase in case-mix between CYs 2000 and 2008 that was due to nominal changes in case-mix (this includes the 11.75% case-mix change found in CY 2008).	Four to five years (CYs 2008-2011). An additional adjustment is planned for CY 2012.	2.75% reduction in CY 2008 (recoupment); 2.75% reduction in CY 2009 (recoupment); 2.75% reduction in CY 2010 (recoupment); 3.79% reduction in CY 2011;[1] 3.79% reduction planned for CY 2012, with potential for modification based on new case-mix research	$410 million reduction in CY 2008 final rule $440 million reduction in CY 2009 final rule $480 million reduction in CY 2010 final rule $700 million reduction in CY 2011 final rule	72 Fed. Reg. 25,356 (May 4, 2007) – Home Health PPS Proposed Rule 72 Fed. Reg. 49,762 (Aug. 29, 2007) – Home Health PPS Final Rule 75 Fed. Reg. 70,372 (Nov. 17, 2010) – Home Health PPS Final Rule There was no legislative action (case-mix adjustments were done entirely by regulation).

[1] CMS increased the payment adjustment from 2.71% to 3.79% in 2011 to account for the additional increase identified in the 2011 analysis.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Long Term Care Hospitals	3-year phase-in of a payment policy adjusting the amount paid to co-located long-term care hospitals within a hospital (LTCH HwHs) if patients admitted from the host hospital are in excess of 25% or an applicable percentage threshold specified for special situations. Payment is based on the lesser of the LTCH PPS payment or an amount equivalent to what would have been paid under the otherwise unadjusted IPPS. ********** Beginning in July 2007, CMS extended the 25% rule to apply to all freestanding LTCHs,	Three years for HwHs and satellites (FYs 2006-2008) ********** Three years for all freestanding LTCHs (RYs 2008-2010)	25% rule applied to HWHs and satellites: Threshold set at 75% for FY 2006; Threshold set at 50% for FY 2007; Threshold set at 25% for FY 2008 ********** 25% rule applied to all freestanding LTCHs: Threshold set at 75% for RY 2008	$460 million projected reduction in estimated aggregate payments for 5 years due to the expansion of the 25% rule to freestanding LTCHs between RYs 2008 and 2012	69 Fed. Reg. 48,916 (Aug. 11, 2004) 72 Fed. Reg. 26,870 (May 11, 2007) 73 Fed. Reg. 24,871 (May 6, 2008) Payment adjustment related to co-location of a LTCH HwH or satellite and a host hospital was implemented in the IPPS final rule for FY 2005. The policy was expanded to all freestanding LTCHs in the LTCH PPS final rule for RY 2008. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) rolled back the phased-in implementation of the 25 percent rule for HWHs and satellites and prevented application of the rule to freestanding LTCHs for three years. The Patient Protection and Affordable Care Act and the Health Care Education Reconciliation Act of 2010

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
	limiting the proportion of patients who can be admitted to an LTCH from any one acute care hospital during a cost reporting period.				extended the roll-back for an additional two years, until 2012.
Inpatient Rehabilitation Facilities	Increase in payments following the implementation of the IRF PPS in FY 2002 based on nominal changes in coding.	Two years (FYs 2006-2007)	1.9% reduction in FY 2006; 2.6% reduction in FY 2007	$120 million reduction in FY 2006 $180 million reduction in FY 2007	70 Fed. Reg. 47,880 (Aug. 15, 2005) 71 Fed. Reg. 48,354 (Aug. 18, 2006) RAND estimated that between 1.9% and 5.9% of the change in case-mix under the new IRF PPS was attributable to nominal changes in provider coding practices. These percentages were used by CMS to make IRF PPS payment reductions.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Inpatient Rehabilitation Facilities	Extended phase-in of the Inpatient Rehabilitation Facility (IRF) Classification Criteria.	Five year phase-in from 50% to 75% threshold (FYs 2004-2008); thresholds modified during FYs 2006-2008; threshold capped at 60% retroactive to cost reporting periods beginning on or after July 1, 2007.	In 2007, the threshold was capped at 60%, retroactive to cost reporting periods beginning on or after July 1, 2007. *Prior to* the threshold being capped at 60%, the phase-in was scheduled as follows: 50% for cost reporting periods beginning on or after July 1, 2004, through June 30, 2005; 60% for cost reporting periods beginning on or after July 1, 2005, through June 30, 2006; 60% (originally 65%) for cost reporting periods beginning on or after July 1, 2006, through June 30, 2007; 65% (originally 75%)	Projected savings included in the FY 2004 Final Rule on Classification Criteria FY 2004: 3 months at 50%; $0 reduction FY 2005: 9 months at 50%, 3 months at 60%; $10 million reduction FY 2006: 9 months at 60%, 3 months at 65%; $30 million reduction FY 2007: 9 months at 65%, 3 months at 75%; $90 million reduction FY 2008: 12 months at 75%; $190 million reduction	69 Fed. Reg. 25,752 (May 7, 2004) Section 5005 of the Deficit Reduction Act of 2005 (DRA) modifies the phase-in established in the May 7, 2004 IRF final rule, which updated the classification criteria for IRFs under the Medicare program. The Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) capped the classification criteria threshold at 60%, retroactive to cost reporting periods beginning on or after July 1, 2007.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
			for cost reporting periods beginning on or after July 1, 2007, through June 30, 2008; 75% for cost reporting periods beginning on or after July 1, 2008.		
Hospice Providers	Transition from the budget neutrality adjustment factor (BNAF), which was implemented in 1997 when CMS moved from an outdated wage index to a more current and accurate method for determining hospice payments. To minimize disruption to services during the transition, CMS applied a special budget neutrality adjustment.	Seven years (FY 2010-2016)	The BNAF is reduced by 10% in FY 2010, 15% in FY 2011, and successive 15% reductions from FY 2012 through FY 2016.	$50 million reduction for FY 2010 due to 10% reduction in the BNAF $80 million reduction for FY 2011 due to 25% reduction in the BNAF $90 million reduction estimated for FY 2012 due to 40% reduction in BNAF	74 Fed. Reg. 39,384 (Aug. 6, 2009) 75 Fed. Reg. 42,944 (Jul. 22, 2010) 76 Fed. Reg. 26,806 (May 9, 2011) CMS originally implemented the phase out of the BNAF over 3 years starting in FY 2007. The 3-year phase out was postponed by one year in the American Recovery and Reinvestment Act of 2009, and CMS was directed to reinstate the BNAF in the calculation of the hospice wage index retroactive to Oct. 1, 2008. In FY 2010, CMS adopted a schedule to phase out the BNAF over 7 years.

Provider Type	Reason for Payment Adjustment	Years of Phase-In	Payment Adjustments (Percentages)	Payment Adjustments (Dollar Amounts)	Legislative/Regulatory Action
Outpatient PPS	Transition to community mental health center (CMHC) partial hospitalization program (PHP) ambulatory payment classification group (APC) per diem rates based on CMHC data only over 2 years.	Two years (CYs 2011-2012)	24.1% decrease in payments to CMHCs due to APC policy changes in CY 2011		75 Fed. Reg. 71,800, 71,992-93 (Nov. 24, 2010) CMHC advocates believed the policy would result in a 41% reduction in Medicare reimbursements, which would lead to center closures if implemented in one year. In response to comments to the proposed rule, CMS decided in the final rule to allow for a two-year transition to the new methodology. The 2011 transition year rates will be calculated by taking 50% of the difference between the medians of the 2010 methodology and the new methodology and adding that number to the new final 2011 CMHC medians. The new rates are expected to be fully implemented in 2012. There was no apparent legislative action driving this adjustment.

Appendix D: Proposed Alternative Parity Adjustment Methodology

CMS FY 2012 SNF PPS Proposed Rule **DRAFT**

American Health Care Assocation Comments

Alternative Methodology For Applying Parity Adjustment: Variable Percentage Add-On To Nursing Index

Old RUG System

RUG Category	Unadjusted Nursing Per Diem	Nursing CMI	Unadjusted Therapy Per Diem	Therapy CMI	Therapy Non-Case Mix	Non-Case Mix	Total Rate	Days	Total Revenue
RUG_CB	$100.00	3	$50.00	2		$25.00	$425.00	100	$42,500
RUG_CA	$100.00	3	$50.00	1		$25.00	$375.00	100	$37,500
RUG_BB	$100.00	2	$50.00	2		$25.00	$325.00	100	$32,500
RUG_BA	$100.00	2	$50.00	1		$25.00	$275.00	100	$27,500
RUG_A2	$100.00	3			$25.00	$25.00	$350.00	100	$35,000
RUG_A1	$100.00	2			$25.00	$25.00	$250.00	100	$25,000
								TOTAL	$200,000

New RUG System

RUG Category	Unadjusted Nursing Per Diem	Nursing CMI	Unadjusted Therapy Per Diem	Therapy CMI	Therapy Non-Case Mix	Non-Case Mix	Total Rate	Days	Total Revenue
RUG_CB	$100.00	2	$50.00	2		$25.00	$325.00	100	$32,500
RUG_CA	$100.00	2	$50.00	1		$25.00	$275.00	100	$27,500
RUG_BB	$100.00	1	$50.00	2		$25.00	$225.00	100	$22,500
RUG_BA	$100.00	1	$50.00	1		$25.00	$175.00	100	$17,500
RUG_A2	$100.00	2			$25.00	$25.00	$250.00	100	$25,000
RUG_A1	$100.00	1			$25.00	$25.00	$150.00	100	$15,000
								TOTAL	$140,000

Parity Adjusted New RUG System: Fixed %age Add-on To Nursing Index (CMS methodology)

RUG Category	Unadjusted Nursing Per Diem	Nursing CMI	Unadjusted Therapy Per Diem	Therapy CMI	Therapy Non-Case Mix	Non-Case Mix	Total Rate	Days	Total Revenue	Percentage Increase In Final Rate	Fixed Add-on %
RUG_CB	$100.00	3.333332	$50.00	2		$25.00	$458.33	100	$45,833	141.0256%	66.6666%
RUG_CA	$100.00	3.333332	$50.00	1		$25.00	$408.33	100	$40,833	148.4848%	
RUG_BB	$100.00	1.666666	$50.00	2		$25.00	$291.67	100	$29,167	129.6296%	
RUG_BA	$100.00	1.666666	$50.00	1		$25.00	$241.67	100	$24,167	138.0952%	
RUG_A2	$100.00	3.333332			$25.00	$25.00	$383.33	100	$38,333	153.3333%	
RUG_A1	$100.00	1.666666			$25.00	$25.00	$216.67	100	$21,667	144.4444%	
								TOTAL	$200,000		

Parity Adjusted New RUG System: Variable %age Add-on To Nursing Index (Proposed Alternative Methodology)

RUG Category	Unadjusted Nursing Per Diem	Nursing CMI	Unadjusted Therapy Per Diem	Therapy CMI	Therapy Non-Case Mix	Non-Case Mix	Total Rate	Days	Total Revenue	Percentage Increase In Final Rate	Variable Add-on %
RUG_CB	$100.00	3.392857	$50.00	2		$25.00	$464.29	100	$46,429	142.8571%	69.6429%
RUG_CA	$100.00	3.178571	$50.00	1		$25.00	$392.86	100	$39,286	142.8571%	58.9286%
RUG_BB	$100.00	1.964286	$50.00	2		$25.00	$321.43	100	$32,143	142.8571%	96.4286%
RUG_BA	$100.00	1.75	$50.00	1		$25.00	$250.00	100	$25,000	142.8571%	75.0000%
RUG_A2	$100.00	3.071429			$25.00	$25.00	$357.14	100	$35,714	142.8571%	53.5714%
RUG_A1	$100.00	1.642857			$25.00	$25.00	$214.29	100	$21,429	142.8571%	64.2857%
								TOTAL	$200,000		

Getting to the Variable Percentage Add-on

1 Compute Overall Percentage Difference in Total Payments between Old system and New system **42.8571%**
(Total rate for each RUG category under variable add-on method should go up by the overall system percentage and achieve budget neutrality)
2 Apply overall percentage to total revenue under New system to compute what revenue by rug should be under the new system (See B60-65)
3 Compute adjusted final rate by dividing adjusted total revenue by Medicare days for each RUG category
4 Compute the adjusted nursing component by subtracting the other components of the RUG rate from the adjusted final rate for each RUG category
5 Compute the difference between the adjusted nursing component and the base nursing component for each RUG category
6 Compute the variable add-on to the nursing component for each RUG category

RUG Category	Adjusted Revenue	Adjusted Final Rate	Adjusted Nursing Componen	Compute Componen Difference	Compute Variable Add-on
RUG_CB	$46,429	$464.29	$339.29	$139.29	69.64%
RUG_CA	$39,286	$392.86	$317.86	$117.86	58.93%
RUG_BB	$32,143	$321.43	$196.43	$96.43	96.43%
RUG_BA	$25,000	$250.00	$175.00	$75.00	75.00%
RUG_A2	$35,714	$357.14	$307.14	$107.14	53.57%
RUG_A1	$21,429	$214.29	$164.29	$64.29	64.29%
TOTAL	$200,000				