American Hospital Association

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July 12, 2005

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

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

Dear Dr. McClellan:

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

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

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

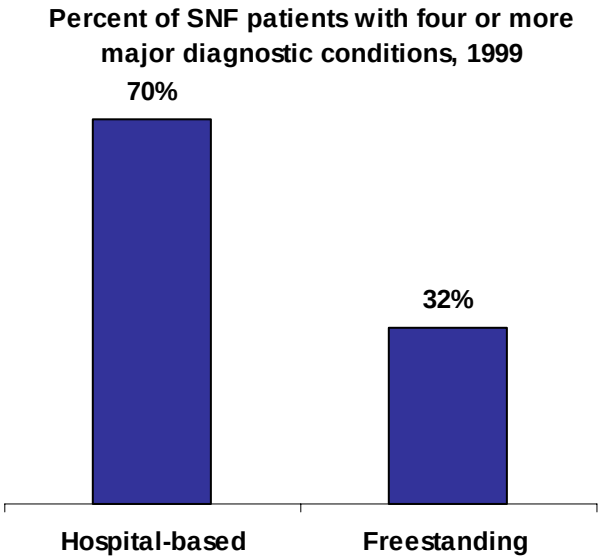
Until a comprehensive remedy is available, CMS should adopt measures to provide relief to hospital-based SNFs because they serve a disproportionate share of medically complex patients. **We urge CMS to add an outlier policy to the SNF PPS to support very high-cost patients and a facility adjustment for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

Hospital-based SNFs: A Unique Model of Care

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

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

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



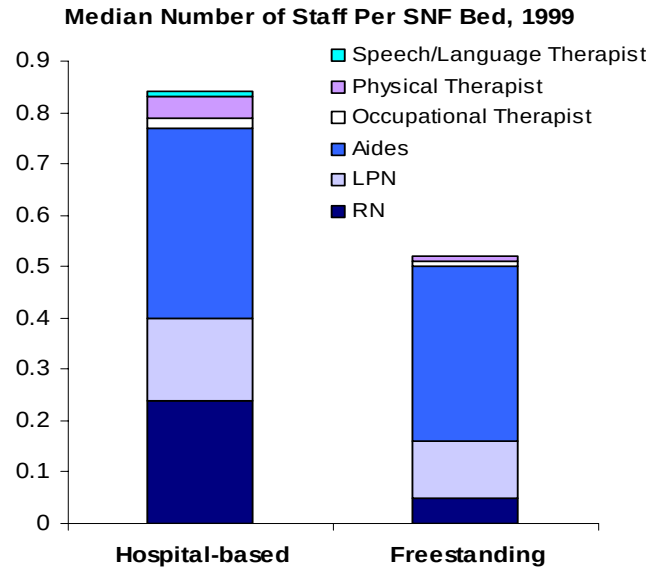
Source: Liu, K and Black K. "Hospital-based and Freestanding Skilled Nursing Facilities: Any Cause for Differential Medicare Payments?" *Inquiry* 40:94-104, Spring 2003.

Hospital-based SNFs Employ More Skilled Staff

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

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

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



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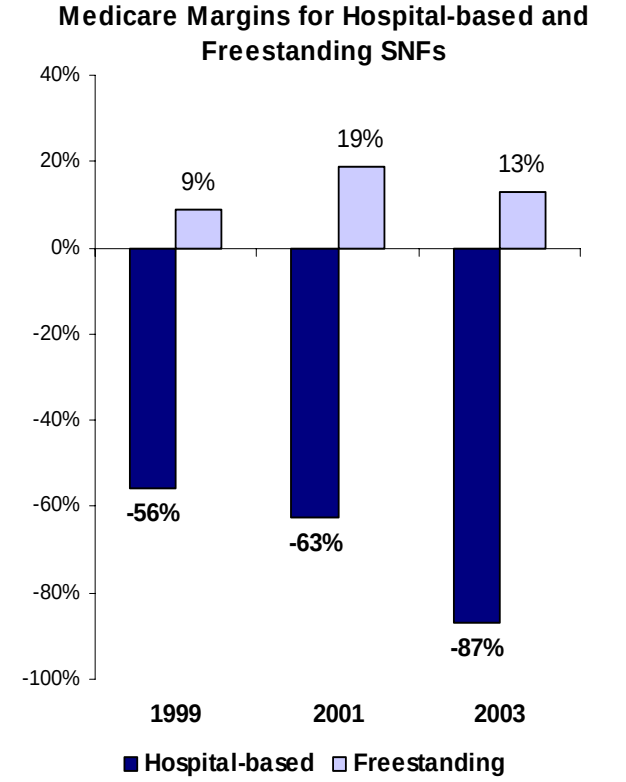


Source: MedPAC Data Book, June 2004, MedPAC December 2004 Meeting Transcripts and MedPAC March 2004 Report.

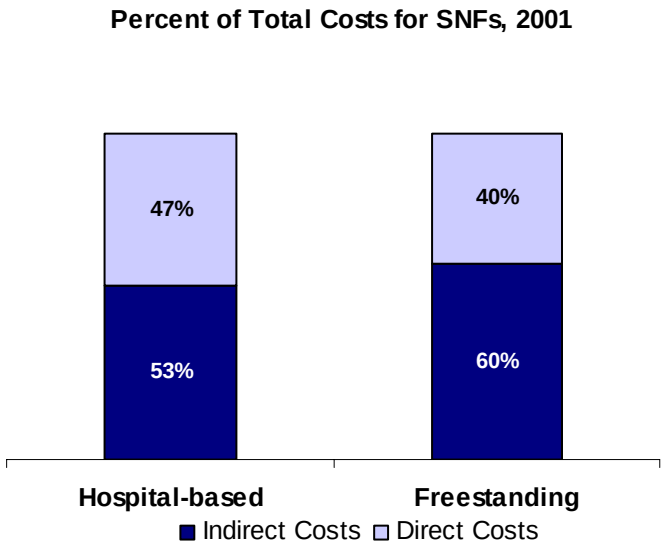
Hospital-based SNFs Spend Less on Overhead per Medicare Dollar

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

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

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

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



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

Congress Supports Care For Medically Complex SNF Patients

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

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

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

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

Proposed Refinements to the Case-mix Classification System

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

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

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

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

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

Recommendations

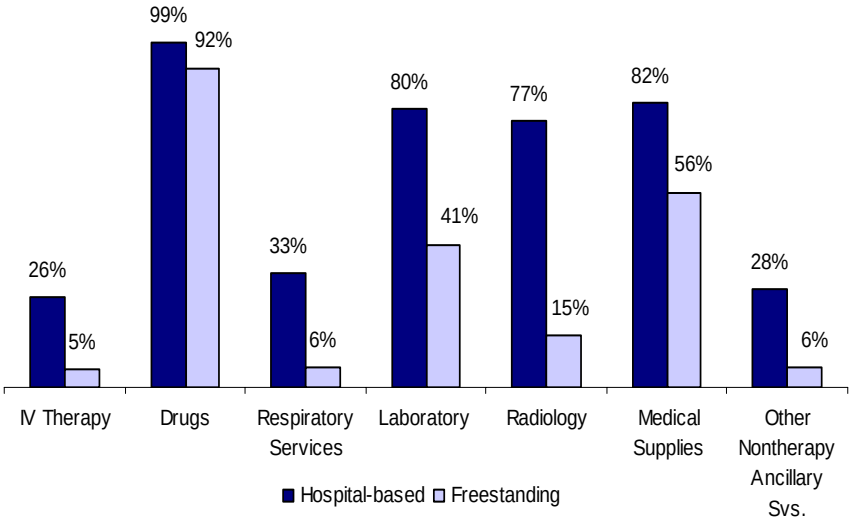
We believe the core problem with the current SNF PPS and the proposed rule is the failure to fully reimburse hospital-based SNFs for the nontherapy ancillary services they provide. On average, the higher acuity caseloads in hospital-based SNFs require more nursing time and nontherapy ancillary services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

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

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

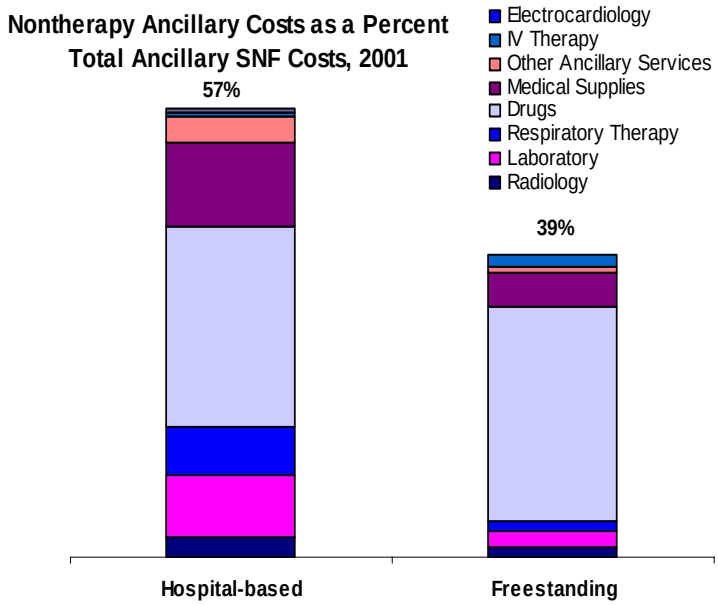
Further, the proposed rule notes that the addition of nine new payment categories would only minimally increase the current payment system's low predictive ability (from an r-square of 4.1 percent to 9.5 percent). Therefore, under the proposed rule, underpayment of nontherapy ancillaries would persist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

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



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

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



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

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

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

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

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

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

MDS Procedural Changes Should Not Be Considered in Isolation

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

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

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

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

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

Other Issues

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

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

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

Sincerely,

Rick Pollack
Executive Vice President